

MARYLAND STATE DEPARTMENT OF HEALTH

04321

4349

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sparrows Point</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Sparrows Point</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>Rheem Co North Pci nt Rd</u>	
3. NAME OF DECEASED (Type or Print).	(First) <u>Raymond</u> (Middle) <u>T</u> (Last) <u>Adamson</u>	4. DATE OF DEATH	(Month) <u>May</u> (Day) <u>25</u> (Year) <u>1955</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, <u>WIDOWED</u> DIVORCED. (Specify)	8. DATE OF BIRTH <u>April 15 1920</u>
10a. USUAL OCCUPATION (Give kind of work done durlog most of working life, even if retired) <u>production sec</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rheem Mfg</u>	11. BIRTHPLACE (State or foreign country) <u>Penn</u>
13. FATHER'S NAME <u>Alex Adamson</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Matthews</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES</u>		16. SOCIAL SECURITY No. <u>2</u>	
17. INFORMANT AND ADDRESS <u>Virginia Adamson 106 Kinship Rd</u>		12. CITIZEN OF WHAT COUNTRY?	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> Immediate cause (a) <u>Cornary Occlusion</u> Antecedent cause(s) (b) <u>Disease or conditions, if any, giving rise to the above cause stating the underlying cause last</u> (c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>0</u>	19b. MAJOR FINDINGS OF OPERATION <u>Heart</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Home</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE MD Adamson MD (Degree or title) ADDRESS Dep. Med. Exam - Dundalk - Md DATE SIGNED 5/25/55

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>May 26, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Meadow Ridge</u>	LOCATION (City, town, or county) (State) <u>Dorsey, Md.</u>
DATE REC'D BY LOCAL REG <u>5-25-55</u>	REGISTRAR'S SIGNATURE <u>MD Adamson</u>	24. FUNERAL DIRECTOR <u>Ullrich Funeral Home</u>	ADDRESS <u>2112 Dundalk Ave.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



FREDERICK

© 1904

4350

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE		MARYLAND		STATE MARYLAND		COUNTY SOMERSET	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN FORT HOWARD		45 DAYS		OR TOWN CRISFIELD		19-39-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL				STREET ADDRESS (If rural give location) P. O. BOX 481			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
BENJAMIN (NMI) AMES				OF DEATH: MAY 9, 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
MALE	COLORADO	WIDOWED	3-5-93	62 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
OYSTER SHUCKER						Accomac, Virginia	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
BENJAMIN AMES				MARY BYRD			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
YES (If Yes, give war or dates of service) WW-1				217-03-7865		CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) ERYTHEMA MULTIFORME EXUDATIVUM						2 WEEKS	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. OSTEOCHONDROMA OF VERTEBRA							
UNKNOWN							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
4-14-55				Laminectomy L-4&5, Hemi-Laminectomy L-3 & exploration of cauda equina			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)	
				OF INJURY		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Mar. 25, 1955 , to May 9, 1955 , that I have the deceased and that death occurred at 6:55 PM , from the causes and on the date stated above.							
SIGNATURE Francis G. Dickey				ADDRESS		DATE SIGNED	
FRANCIS G. DICKEY, M.D., Chief, Medical Service, D.				VAH, FORT HOWARD, MARYLAND		5-10-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
BURIAL		5/12/1955		BALTIMORE NATIONAL		BALTIMORE, MARYLAND	
DATE REC'D BY LOCAL		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
5-12-55		ALW. Phillips		ARLINGTON S. PHILLIPS, 1808 N. MONROE ST.		BALTIMORE 17, MARYLAND	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE OF NEW YORK

1910

Page 10

IN SENATE, JANUARY 10, 1910.

REPORT OF THE COMMISSIONERS OF THE LAND OFFICE.

ALBANY: J.B. LIPPINCOTT & CO., 1910.

PRINTED BY THE COMMISSIONERS OF THE LAND OFFICE.

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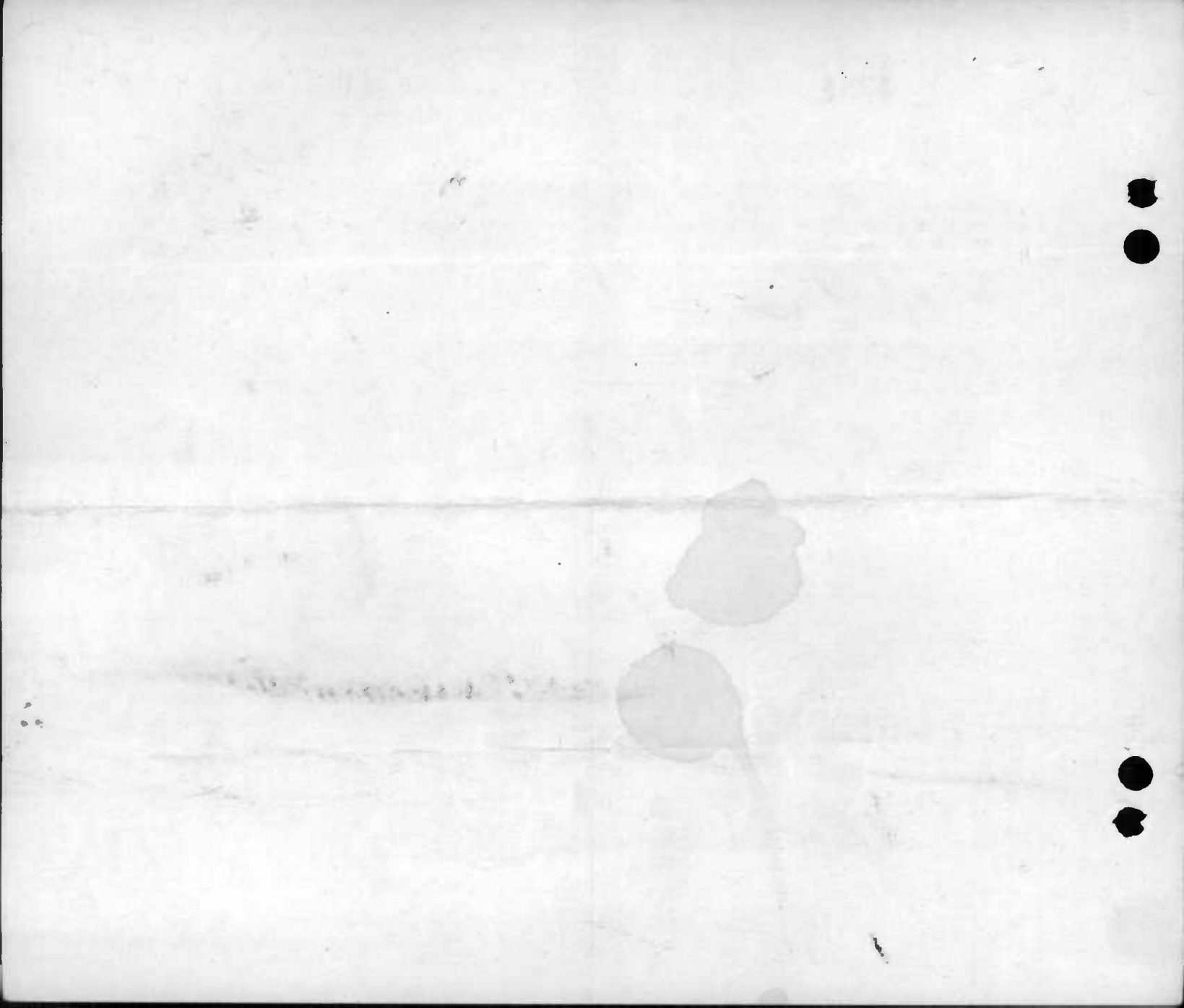
MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

4351

04323 ^{WC}

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sparrans Pt.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u> 3401-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sparrans Pt. Hosp.</u>		STREET ADDRESS (If rural, give location) <u>2510 Madison Ave</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Leroy</u> (Middle) <u>WILLIAM</u> (Last) <u>Anderson</u>	4. DATE OF DEATH	(Month) <u>5</u> (Day) <u>25</u> (Year) <u>1955</u>
5. SEX <u>M.</u>	6. COLOR OR RACE <u>Black</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (State) <u>Married</u>	8. DATE OF BIRTH <u>Mar. 25 1901</u>
9. AGE last birthday <u>54</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. Kind of Business or Industry <u>Steel W.</u>
11. BIRTHPLACE (State or foreign country) <u>Opelika, Kansas</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Severly Anderson</u>		14. MOTHER'S MAIDEN NAME <u>Anna Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>213-07-6821</u>	
17. INFORMANT AND ADDRESS <u>2510 Madison Ave.</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(a) <u>420.1 Coronary Occlusion</u> Immediate cause		<u>10 min.</u>	
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?	
		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office hldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE (Degree or title)		DATE SIGNED	
<u>M. Davis M.D. Dept. Med. Exam. Dundalk. Md.</u>		<u>5/25/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>May 31 1955</u>	<u>Mt. Auburn</u>	<u>Baltimore, Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>5-27-55</u>	<u>W. H. Hodge</u>	<u>Funeral</u>	<u>1631 Spauld Hill Ave</u>



CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		34014	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Codd Nursing Home</u>				STREET ADDRESS (If rural give location) <u>1224 N. Calvert St.</u>			
3. NAME OF DECEASED: (First) <u>Rhea</u> (Middle) <u>Magness</u> (Last) <u>Armstrong</u>				4. DATE OF DEATH: (Month) <u>May</u> (Day) <u>14</u> (Year) <u>1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>		8. DATE OF BIRTH: <u>1878</u>	
9. AGE last birthday: <u>77</u> yrs.		10. USUAL OCCUPATION: Give kind of work done during most of working life, even if retired <u>Housewife</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Henry Magness</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Family Records</u>			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Cerebral Haemorrhage</u>	DUE TO	
Antecedent causes (s) (b) <u>Arteriosclerosis</u>	DUE TO	
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION: <u>May 17, 1955</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from <u>July</u> , 1954, to <u>MAY</u> , 1955, that I last saw the deceased alive on <u>5/11</u> , 1955, and that death occurred at <u>4:10 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>M. E. Quinn</u>		DATE SIGNED <u>5/16/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		NAME OF CEMETERY OR CREMATORY <u>Timonium</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 16, 1955</u>		LOCATION (City, town, or county) <u>Baltimore, Md.</u>	
REGISTRAR'S SIGNATURE <u>Mabel C. Gray</u>		24. FUNERAL DIRECTOR <u>John Burnie' Sons, Towson, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 18 1955

BUREAU V. S.

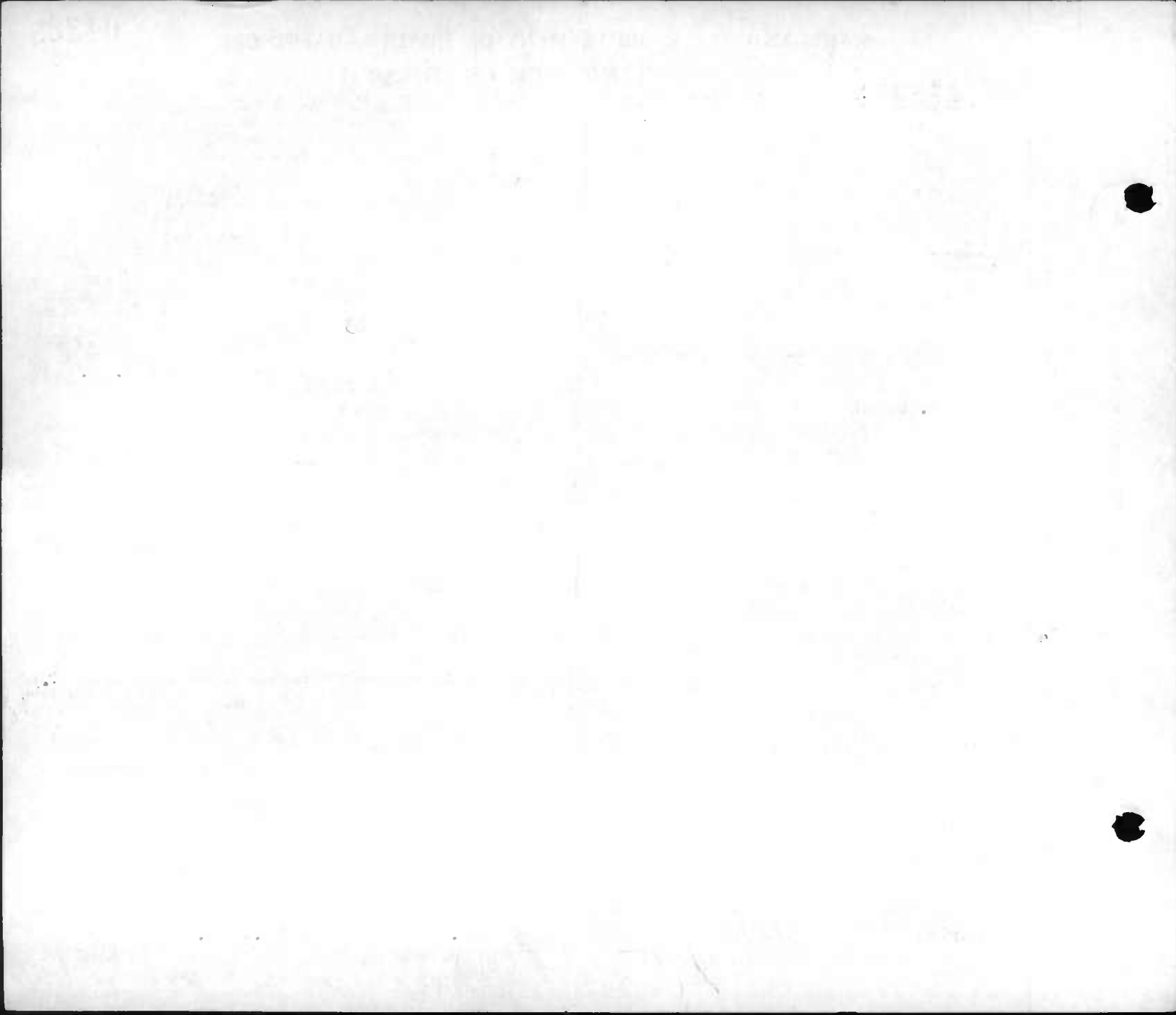
CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Balts City</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>	LENGTH OF STAY (in this place) <u>17 yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore City. 3101.4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove St. Hosp.</u>		STREET ADDRESS (formerly of, give location) <u>3300 N. Calvert Street</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Anne</u>	(Middle) <u>L.</u>	(Last) <u>Aubel</u>	(Date) <u>5. 17 1955</u>
5. SEX <u>F.</u>	6. COLOR OR RACE <u>V.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>	8. DATE OF BIRTH: <u>Nov. 30. 1871</u>
9. AGE last birthday <u>83</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>none</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>London, England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U: S. A.</u>	
13. FATHER'S NAME: <u>John N. Grant</u>		14. MOTHER'S MAIDEN NAME: <u>Emily Buckham</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Hospital Records.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Pulmonary Infarct Embolus</u>			<u>unknown</u>
ANTECEDENT CAUSE (B) <u>Hypertensive Cardiovascular disease</u>			<u>"</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Generalized severe arteriosclerosis</u>			<u>"</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Oct. 19, 1937</u> , to <u>May 17, 1955</u> , that I last saw the deceased alive on <u>5. 17, 1955</u> , and that death occurred at <u>7 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Gertrude J. Fleischer</u>		ADDRESS <u>M. D. Spring Grove</u>	
DATE SIGNED <u>5. 17. 55.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/20/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-19-55</u>		REGISTRAR'S SIGNATURE <u>aw Hedrick</u>	
FUNERAL DIRECTOR <u>Thm. J. Pickens & Sons</u>		ADDRESS <u>Balto. 17</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04326

4354

CERTIFICATE OF DEATH

Reg. Dist. No. 34

1. PLACE OF DEATH- COUNTY BALTIMORE COUNTY MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MARYLAND COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWSON		CITY (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS TOWSON NURSING HOME		STREET ADDRESS (If rural, give location) 3117 BELAIR ROAD	
3. NAME OF DECEASED (Type or Print) ELIZABETH BAER	(First) (Middle) (Last)	4. DATE OF DEATH MAY 10, 1955	(Month) (Day) (Year)
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOW	8. DATE OF BIRTH JAN. 14, 1872
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE GRAU SR.		14. MOTHER'S MAIDEN NAME ELIZABETH ROTH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY No. NONE	
17. INFORMANT AND ADDRESS MRS KATHERINE HALL		18. SAME.	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		13. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause 422.1		(a) Chronic myeloid leukaemia	1 yr.
Antecedent cause(s)		(b) Arterio-sclerotic	5 yr.
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) SUICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from....., 1949, to....., 1955, that I last saw the deceased alive on....., 1955, and that death occurred at..... m., from the causes and on the date stated above.

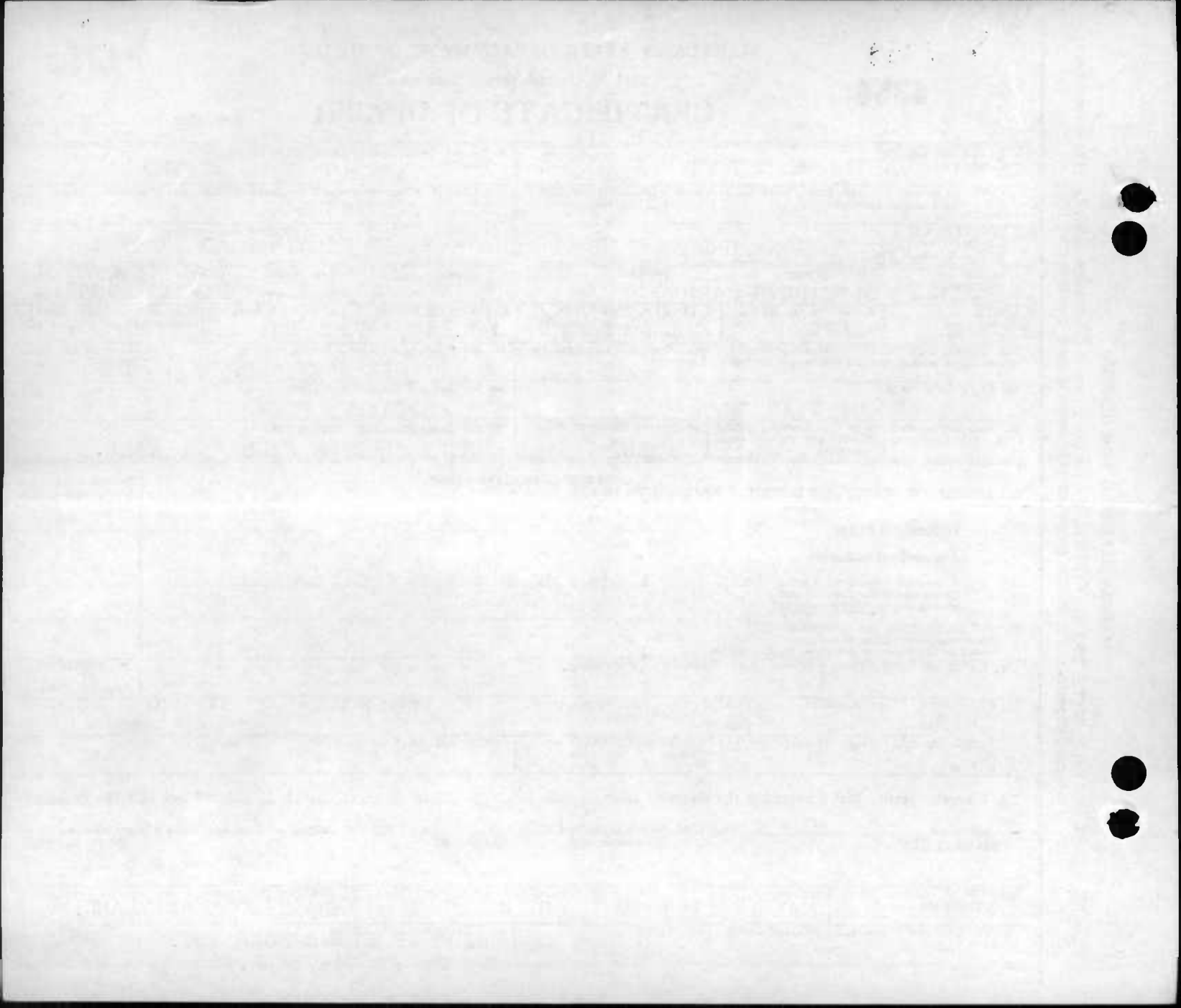
SIGNATURE **John Moore M.D.** ADDRESS **3105 Belair Rd** DATE SIGNED **5-10-55**

23. BURIAL CREMATION (Specify) BURIAL	DATE MAY 13, 1955	NAME OF CEMETERY OR CREMATORY BALTIMORE CEMETERY	LOCATION (City, town, or county) (State) BALTIMORE MARYLAND.
DATE REC'D BY LOCAL REG. 5-13-55	REGISTRAR'S SIGNATURE John Moore	24. FUNERAL DIRECTOR HENRY SANDER & SONS INC.	ADDRESS BALTIMORE MARYLAND.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4355

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04327C

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
TOWN <u>Ruxton</u>		<u>9 months</u>		TOWN <u>Ruxton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1300 Berwynck Avenue</u>				STREET ADDRESS (If rural give location) <u>1300 Berwynck Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Marion Valentine Bailliere</u>				<u>May - 12 19 55</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Apr - 19 - 1884</u>	
9. AGE last birthday <u>71</u> yrs.		10. UNDER 1 YEAR Months Days		11. BIRTHPLACE (State or foreign country): <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY?	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Consulting Engineers</u>			
13. FATHER'S NAME: <u>Frederick H. Bailliere</u>				14. MOTHER'S MAIDEN NAME: <u>Evalina Mary Tabb</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>?</u> (If Yes, give war or dates of service) <u>?</u>				16. SOCIAL SECURITY NO. <u>270-09-9666A</u>		17. INFORMANT & ADDRESS: <u>Mrs. Ewing W. Brand (daughter) Ruxton</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
578X IMMEDIATE CAUSE (A) <u>Hemorrhage, Gastro-intestinal, Massive -</u>							
ANTECEDENT CAUSE (B) <u>Cause unknown</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerosis Cardio-vascular disease ? years</u>							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 14, 1954</u> , to <u>May 12, 1955</u> , that I last saw the deceased alive on <u>May 12, 1955</u> , and that death occurred at <u>3:15 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>M. D. George S. Watson</u>				DATE SIGNED <u>May 13, 1955</u>			
23. BURIAL, CREMATION, REMOVAL, (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May-16/55</u>		NAME OF CEMETERY OR CREMATORY <u>Ware Church</u>		LOCATION (City, town, or county) (State) <u>Gloucester Co., Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-13-55</u>		REGISTRAR'S SIGNATURE <u>W. Hedrick</u>		24. FUNERAL DIRECTOR <u>Stewart & Morrow Co.</u>		ADDRESS <u>108 W. North Ave. Balto.</u>	

4356

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 55 Towson		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 3V01-4			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 96 Armacost Nursing Home				STREET ADDRESS (If rural give location) 1807 East 31st Street #18			
3. NAME OF DECEASED: MARY (First) Agnes (Middle) Bannon (Last)				4. DATE (Month) (Day) (Year) OF DEATH: May 25th 1955			
5. SEX: female		6. COLOR OR RACE: white		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single		8. DATE OF BIRTH: Jan 20 1892	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shirt Mfg.		10B. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday 63 yrs.		11. BIRTHPLACE (State or foreign country): Baltimore, Maryland	
13. FATHER'S NAME: Michael Bannon				12. CITIZEN OF WHAT COUNTRY? USA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				14. MOTHER'S MAIDEN NAME: Margaret ?			
15. SOCIAL SECURITY NO.				17. INFORMANT & ADDRESS: Mr. Vincent Lowe, 313 Worthington Rd #4			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) General Carcinomatosis						1 year	
ANTECEDENT CAUSE (B) Carcinoma of Bladder						2 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 1/7/55				19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7/25 , 19 53 , to 5/25 , 19 55 , that I last saw the deceased alive on 5/27 , 19 55 , and that death occurred at 6:30 A.M. from the causes and on the date stated above.							
SIGNATURE J. J. Zimber				ADDRESS M. D. 2320 E. Lomb Rd		DATE SIGNED 5/25/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May 27, 1955		NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		LOCATION (City, town, or county) (State) Baltimore, Maryland	
DATE REC'D BY LOCAL REGISTRAR 5/28/55		REGISTRAR'S SIGNATURE W. D. Hadley		24. FUNERAL DIRECTOR Leonard J. Ruck		ADDRESS 5305 Harford Road #14	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Israel Zinberg
2320 Eutaw Place
LA 3 5737

2:30 To 6

YAHN

ed 1931 10/11

04329

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

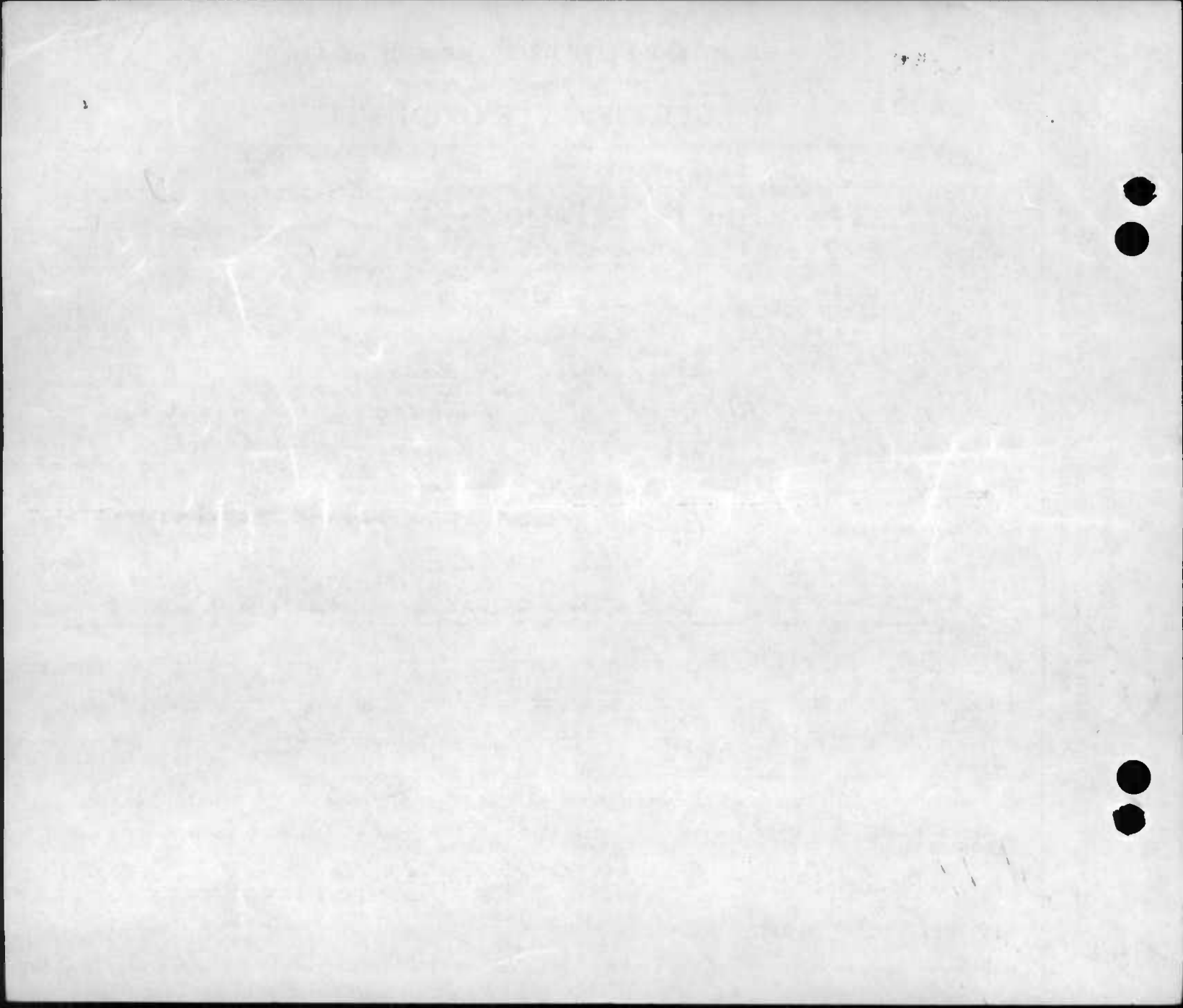
Reg. Dist. No. *14*

4357

1. PLACE OF DEATH- COUNTY <i>BALTIMORE</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>MD</i> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Spawne Pt.</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>MD</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>7700 Bay Front Rd.</i>		STREET ADDRESS (If rural, give location) <i>#1.</i>	
3. NAME OF DECEASED (Type or Print) <i>CHARLES</i> (First) (Middle) (Last) <i>BARTOSH</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>MAY 5 1955</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>Dec 5, 1889</i>
9. AGE last birthday <i>65 yrs.</i>		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Store Keeper</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Grocery</i>	
11. BIRTHPLACE (State or foreign country) <i>Lithuania</i>		12. CITIZEN OF WHAT COUNTRY? <i>Same</i>	
13. FATHER'S NAME <i>Kagmer Bartosh</i>		14. MOTHER'S MAIDEN NAME <i>Antonia Ushniowska</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY No. <i>216-32-9610</i>	
17. INFORMANT AND ADDRESS <i>Agatha Bartosh (wife) above</i>		18. MEDICAL CERTIFICATION <i>as agreed</i>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>443X Immediate cause</i>		INTERVAL BETWEEN ONSET AND DEATH	
(a) <i>Gastric ulcer with massive hemorrhage</i>		<i>3 days</i>	
(b) <i>diabetes mellitus</i>		<i>3 months</i>	
(c) <i>Hypertensive Cardiovascular disease</i>		<i>4 yrs.</i>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Sep 5, 1951</i> to <i>May 5, 1955</i> , that I last saw the deceased alive on <i>May 5, 1955</i> , and that death occurred at <i>2:30 P</i> m., from the causes and on the date stated above.			
SIGNATURE <i>Louis N. Tallin M.D.</i>		ADDRESS <i>6908 N. P+ Rd. Balto. 19. Md</i>	
DATE SIGNED <i>5/5/55</i>			
23. BURIAL CREMATION REMOVAL (Specify) <i>Buried</i>		DATE THEREOF <i>May 9</i>	
NAME OF CEMETERY OR CREMATORY <i>Landon Park</i>		LOCATION (City, town, or county) (State) <i>Wilmington Md.</i>	
24. FUNERAL DIRECTOR <i>Charles W. Rachauskas</i>		ADDRESS <i>703 N. Henry St</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4358

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04350
CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Howard</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Owings Mills</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Jessups</u> 13X-2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rosewood Training School</u>				STREET ADDRESS (If rural, give location) ✓			
3. NAME OF DECEASED: (Type or Print) <u>Alma</u>		(First) <u>Eugenia</u>		(Last) <u>Basford</u>		4. DATE OF DEATH: (Month) <u>5</u> (Day) <u>23</u> (Year) <u>19 55</u>	
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>	8. DATE OF BIRTH: <u>10/23/06</u>		9. AGE last birthday: <u>48</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ---		10b. KIND OF BUSINESS OR INDUSTRY: ---		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Joseph S. Basford</u>				14. MOTHER'S MAIDEN NAME: <u>Isabel Reely Basford (Deceased)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY No.: ---		17. INFORMANT & ADDRESS: <u>Rosewood Records</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>491X</u> Immediate cause (a)..... <u>Broncho - Pneumonia, Acute -</u>						<u>4 1/2 mos</u>	
DUE TO							
Antecedent cause(s) (b)..... <u>Bronchitis, Acute -</u>						<u>2 weeks -</u>	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c).....							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>0</u>				19b. MAJOR FINDINGS OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/4/</u> 19 <u>40</u> to <u>5/23</u> 1955 , that I last saw the deceased alive on <u>5/23</u> 19 <u>55</u> , and that death occurred at <u>9:30</u> a.m. from the causes and on the date stated above.							
SIGNATURE <u>Harry G. Butler M.D.</u>				(DEGREE OR TITLE) <u>Owings Mills, Maryland</u>		DATE SIGNED	
23. BURIAL, CREMATION REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>May 25-55</u>		NAME OF CEMETERY OR CREMATORY <u>Savage Cemetery</u>		LOCATION (City, town, or county) (State) <u>Savage, Md</u>	
DATE REC'D BY LOCAL REG. <u>May 25-1955</u>		REGISTRAR'S SIGNATURE <u>Mary Elmer</u>		24. FUNERAL DIRECTOR <u>Edw. W. Donaldson</u>		ADDRESS <u>Laurel, Md</u>	

BUREAU V. S.

MAY 31 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2, Film 181 5-16-55 et

04331

4359

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u> <u>03-52</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 Catonsville Nursing Home</u>				STREET ADDRESS (If rural give location) <u>Frederick Rd. & Nunnery Lane 1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>CONRAD BECKER</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>May 9th., 1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify) <u>Widower</u>	8. DATE OF BIRTH: <u>7/19/1856</u>	9. AGE last birthday <u>98</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Merchant</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Grocery Business</u>		11. BIRTHPLACE (State or foreign country): <u>Germany</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Md. Mr. W. F. Becker 6224 Frederick Ave. Catons.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Myocardial failure</u>						<u>72 hrs</u>	
ANTECEDENT CAUSE (B) DUE TO <u>A.S.C.V.D.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Unknown</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 27, 1950</u> , to <u>5-9</u> , 1955, that I last saw the deceased alive on <u>5-9</u> , 1955, and that death occurred at <u>3:00 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Stephen Lee Magness</u>		M. D. <u>Catonsville</u>		DATE SIGNED <u>5-10-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/11/55</u>		NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/10/55</u>		REGISTRAR'S SIGNATURE <u>V.E. Harry</u>		24. FUNERAL DIRECTOR <u>Easton Sons</u>		ADDRESS <u>Catonsville, Md.</u>	

RECEIVED

MAY 12 1955

BUREAU V. S.

4360

CERTIFICATE OF DEATH

Reg. Dist. No. 37

Items 8,9,12 FilmG181 5-19-55 et

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Texas - Cockeysville P.O.</u>		<u>1 yr. 7 mo.</u>		TOWN <u>Sparrows Point</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Baltimore County Home</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>JOHN BIELECKI</u>				<u>MAY 14 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.		
<u>MALE</u>	<u>WHITE</u>	<u>WIDOWED</u>	<u>Unknown</u>	<u>Approx. 70 yrs.</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): <u>FA RM LABO RER</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>FA RM</u>		11. BIRTHPLACE (State or foreign country): <u>White Russia here since 1917</u>		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>3 no</u>		16. SOCIAL SECURITY No.: <u>220-01-1735</u>		17. INFORMANT & ADDRESS: <u>Mrs. Julia Orndorff - 2407 Ruth Ave. Sparrows Point</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				Interval Between Onset And Death			
422.1 Immediate cause (a) <u>Cardiac decompensation</u>				<u>years</u>			
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Arteriosclerotic cordis vascular disease</u>				<u>years</u>			
(c)							
II. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY ?				Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR ?			
22. I hereby certify that I attended the deceased from <u>Oct. 13</u> , 1953, to <u>May 14</u> , 1955, that I last saw the deceased alive on <u>May 14</u> , 1955, and that death occurred at <u>6:30 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE (Degree or title) <u>Elizabeth B. Skerrell M.D.</u>				DATE SIGNED <u>5/14/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>May 14/55</u>		<u>University of Maryland Medical School</u>		<u>Balto. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>May 14/55</u>		<u>M. J. G. G. G. G.</u>		<u>L. Scott Brooks</u>		<u>Sparrows Point</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 17 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4342

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04333

Item 8, Film G183, 6/30/55

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>md</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) 51 TOWN <u>Arbutus</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Arbutus</u> 51			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00				STREET ADDRESS (If rural, give location) 5549 Runk Ave			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Florence Leuep Bird</u>				4. DATE OF DEATH: <u>May 18 1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>June 19 1887</u>	
9. AGE last birthday: <u>68</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME: <u>Harry Jackson</u>				14. MOTHER'S MAIDEN NAME: <u>Florence Leuep</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No.</u>		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Mr Raymond Mahoney 5549 Runk Ave</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
163X Immediate cause (a) <u>Carcinoma of Lung &</u> DUE TO							
Antecedent cause(s) (b) <u>Terminal Carcinomatosis</u> DUE TO							
(c)							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>0</u>				19b. MAJOR FINDINGS OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
INJURY		INJURY OCCURRED While at Not while work <input type="checkbox"/> at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
TIME (Month) (Day) (Year) (Hour) OF INJURY		M.					
22. I hereby certify that I attended the deceased from <u>2/6</u> 19 <u>54</u> , to <u>5/18</u> 19 <u>55</u> , that I last saw the deceased alive on <u>5/18</u> 19 <u>55</u> , and that death occurred at <u>4:15 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>John C. Eady M.D.</u>		(DEGREE OR TITLE)		ADDRESS <u>Cheltenham 27, Md</u>		DATE SIGNED <u>5/18/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>5-21-55</u>		NAME OF CEMETERY OR CREMATORY <u>London Park</u>		LOCATION (City, town, or county) (State) <u>Baltimore</u>	
DATE REC'D BY LOCAL REG. <u>5-19-55</u>		REGISTRAR'S SIGNATURE <u>A W Hedrick</u>		24. FUNERAL DIRECTOR <u>Edward J. Statbank</u>		ADDRESS <u>4107 Western Ave</u>	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04334

4361

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Fort Howard		8 Days		OR TOWN Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital				STREET ADDRESS (If rural give location) 600 W. North Avenue			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
EARL S. BISHOP				OF DEATH: May 6, 19 55			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	White	Married	1/14/89	66 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter		10B. KIND OF BUSINESS OR INDUSTRY: Consolidated Engrs.		11. BIRTHPLACE (State or foreign country): Imperial, Nebraska		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME: Stephen S. Bishop				14. MOTHER'S MAIDEN NAME: Mary Robbins			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 218-09-2997		17. INFORMANT & ADDRESS: Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) PRIMARY LEFT THORACIC-INLET TUMOR WITH							
ANTECEDENT CAUSE (S) WIDESPREAD METASTASES TO BONE.						UNKNOWN	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 2		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
VA M.							
22. I hereby certify that I attended the deceased from Apr. 28, 1955 to May 6, 1955 and that death occurred at 11:15 M. from the causes and on the date stated above.							
SIGNATURE William B. Vandegriest		ADDRESS M. D. FORT HOWARD, MARYLAND		DATE SIGNED 5/7/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF MAY 10, 1955		NAME OF CEMETERY OR CREMATORY Baltimore National		LOCATION (City, town, or county) (State) Baltimore, Maryland	
DATE REC'D BY LOCAL REGISTRAR 5-7-55		REGISTRAR'S SIGNATURE R. W. Hedgcock		24. FUNERAL DIRECTOR ADDRESS William Cook-Blight Inc 6009 Harford Rd Balto. 14, Md			

MARGIN RESERVED FOR BINDING

M

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04335

4362

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTIMORE</u>	MARYLAND	STATE <u>MARYLAND</u>	COUNTY <u>BALTO</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>PIKESVILLE</u>	<u>X</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00 Hill COLONIAL Rd</u>		STREET ADDRESS (If rural give location) <u>Hill COLONIAL Rd</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>FRANKLIN WALTER Bitz Sr.</u>		OF DEATH: <u>MAY 16 1955</u>	
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>MAY 17 1882</u>
9. AGE last birthday: <u>72</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>TRAFFIC MANAGER</u>		11. BIRTHPLACE (State or foreign country): <u>BALTIMORE MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>WILLIAM J Bitz</u>	
14. MOTHER'S MAIDEN NAME: <u>Emma G. Mueller</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>9</u>	
16. SOCIAL SECURITY No. <u>215-07-5193</u>		17. INFORMANT & ADDRESS: <u>Gullert Bitz</u>	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
157X IMMEDIATE CAUSE (A) DUE TO <u>Crownay thrombosis</u>		<u>2 hrs</u>	
ANTECEDENT CAUSE (B) DUE TO <u>Biliary Obstruction</u>		<u>2 wks</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Carcinoma of the head of the Pancreas</u>		<u>1 yr.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Jamides</u>			
19A. DATE OF OPERATION: <u>1 April 1955</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Ca of the Pancreas.</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1945</u> , to <u>May 16, 1955</u> , that I last saw the deceased alive on <u>May 15, 1955</u> , and that death occurred at <u>7:10 P. M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Luci Salzman</u>		DATE SIGNED <u>8, May 17/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>MAY 20, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>WOODLAWN CEMETERY</u>		LOCATION (City, town, or county) (State) <u>WOODLAWN MD</u>	
DATE REC'D BY LOCAL REGISTRAR <u>MAY 18, 1955</u>		REGISTRAR'S SIGNATURE <u>Harvey A. Newell</u>	
24. FUNERAL DIRECTOR <u>FRANK H. Newell</u>		ADDRESS <u>PIKESVILLE MD</u>	

BUREAU V. S.

MAY 20 1965

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

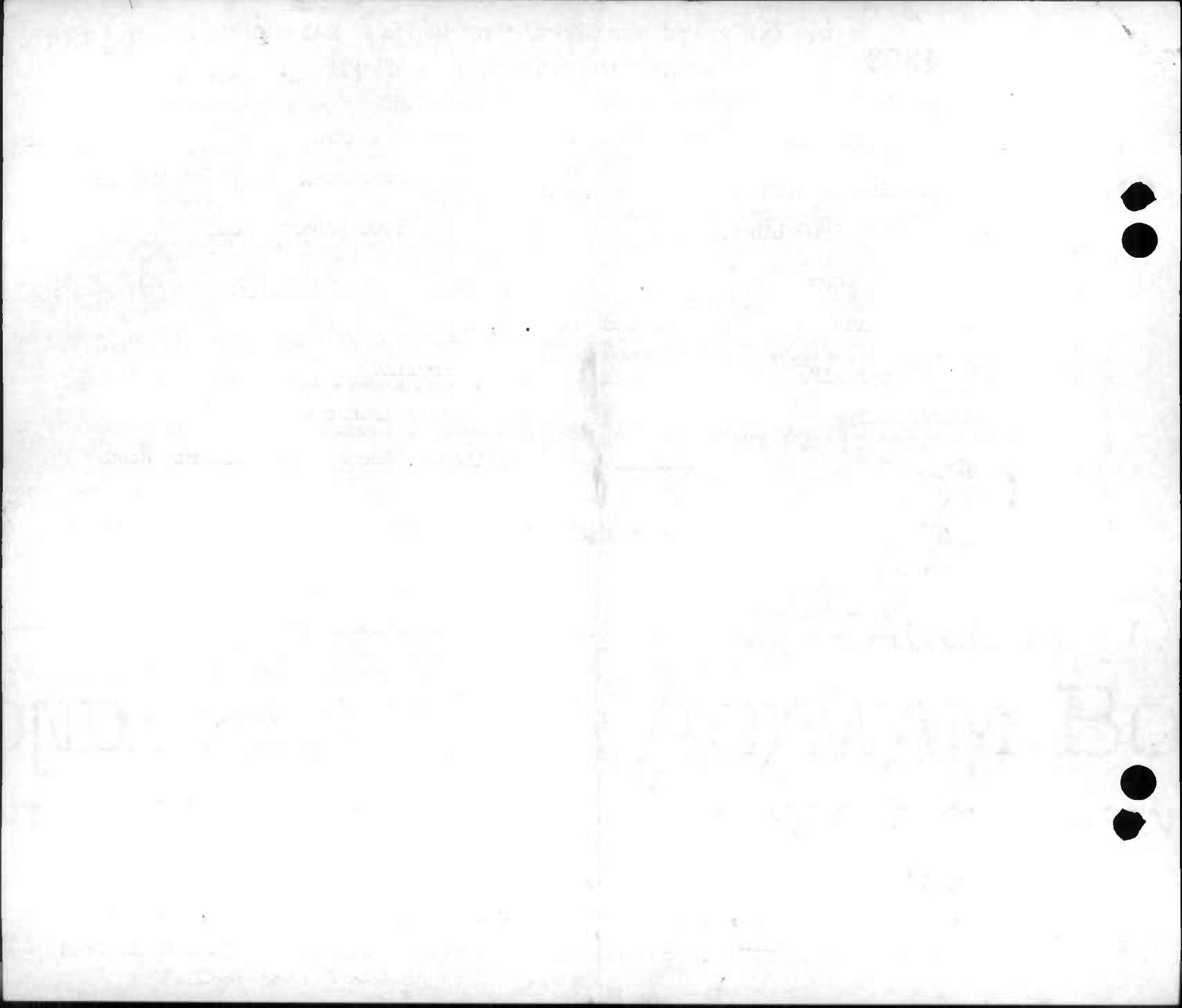
04336

4363

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
<u>X</u> <u>TOWN</u> <u>Immediately North of</u>		<u>10 years</u>		<u>Immediately North of City Line</u> <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Baltimore City Line		STREET ADDRESS		(If rural give location)	
<u>00</u> <u>5908 Liberty Road</u>				<u>5908 Liberty Road</u>			
3. NAME OF DECEASED:			4. DATE OF DEATH:			5. AGE last birthday:	
(First) (Middle) (Last)			(Month) (Day) (Year)			IF UNDER 1 YEAR IF UNDER 24 HRS.	
<u>Mary</u> <u>M.</u> <u>Boone</u>			<u>May</u> <u>20</u> <u>19</u> <u>55</u>			<u>66</u> yrs. Months Days Hours Min.	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>Female</u>		<u>White</u>		<u>Married</u>		<u>Sept. 28, 1888</u>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired.			10b. KIND OF BUSINESS OR INDUSTRY:			11. BIRTHPLACE (State or foreign country):	
<u>Housewife</u>						<u>Maryland</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Joseph Kelly</u>				<u>Susan Isennock</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>4</u> <u>No</u>				<u>William W. Boone</u> <u>5908 Liberty Road</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
<u>174X</u> <u>Immediate cause</u> (a) <u>CARCINOMA OF UTERUS</u>						<u>2 YRS</u>	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the <u>underlying cause last.</u> (b) DUE TO							
(c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION					
<u>2-10-55</u>		<u>BIOPSY - UNDIFFERENTIATED CARCINOMA</u>					
20. AUTOPSY?		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
		INJURY					
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
		m.					
22. I hereby certify that I attended the deceased from <u>2-5</u> , 19 <u>55</u> , to <u>5-20</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-18</u> , 19 <u>55</u> , and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above.							
SIGNATURE		(Degree or title)		ADDRESS		DATE SIGNED	
<u>B. Stanley Cohen</u>		<u>MD</u>		<u>7306 Liberty Rd</u>		<u>Bldg 7 5-20-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 21, 1955</u>		<u>New Cathedral</u>		<u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR		ADDRESS	
<u>5-23-55</u>		<u>[Signature]</u>		<u>Burgee Funeral Home</u>		<u>3631 Falls Road</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04337

4364

CERTIFICATE OF DEATH

Reg. Dist. No. 45

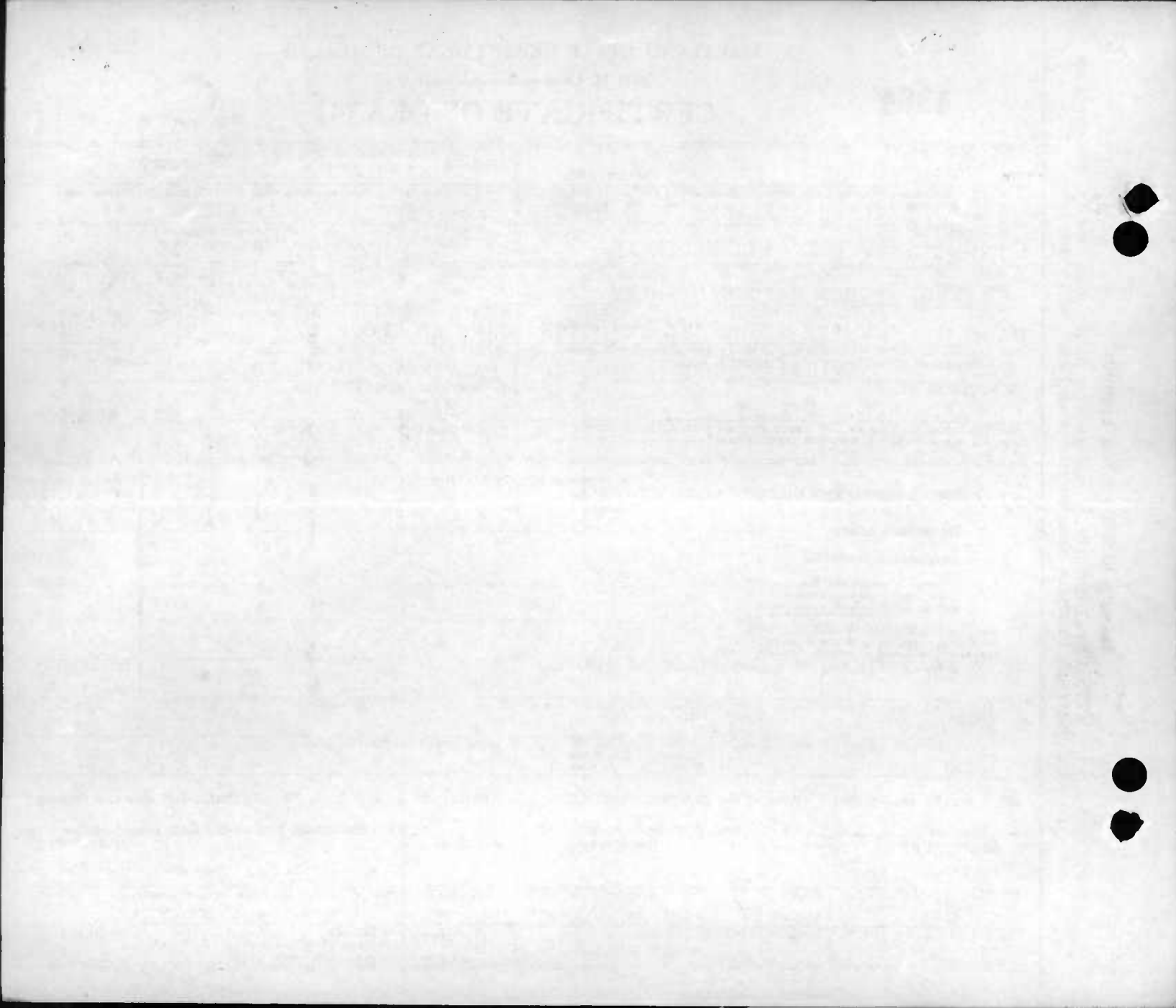
1. PLACE OF DEATH- COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MARYLAND COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN BOWLEYS QUARTERS		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN BOWLEYS QUARTERS	
HOSPITAL OR INSTITUTION OR STREET ADDRESS BOX 295c ROUTE 15		STREET ADDRESS (If rural, give location) BOX 295c ROUTE 15	
3. NAME OF DECEASED (Type or Print) ARTHUR WATSON BORDLEY		4. DATE OF DEATH MAY 27, 1955	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWER		8. DATE OF BIRTH JAN. 25, 1887	
9. AGE last birthday 67 yrs.		10. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPT. TERMINAL WAREHOUSE		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME HARRY F.F. BORDLEY		14. MOTHER'S MAIDEN NAME MARY THOMPSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY No. 212 10 5581	
17. INFORMANT AND ADDRESS 3143 ABELL AVE. MRS ALWYN HUNDLEY JR.			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) 331X Cerebro-vascular accident				8 hrs.	
Antecedent cause(s) (b) Cerebral arteriosclerosis				?	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Rheumatoid arthritis, severe				10 yrs.	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Feb 9, 1955 to Nov. 1954 , that I last saw the deceased alive on Nov 25, 1954 , and that death occurred at 11:00 P.M. , from the causes and on the date stated above.					
SIGNATURE Mawin Goldstein		ADDRESS M.D. 5334 Liberty Heights Ave.		DATE SIGNED 5/28/55	
23. BURIAL, CREMATION REMOVAL (Specify) BURIAL		DATE MAY 31, 1955		NAME OF CEMETERY OR CREMATORY WOODLAWN CEMETERY	
LOCATION (City, town, or county) BALTIMORE MARYLAND.		24. FUNERAL DIRECTOR HENRY SANDER & SONS INC.		ADDRESS BALTIMORE MARYLAND.	
DATE REC'D BY LOCAL REG. 5-31-55		REGISTRAR'S SIGNATURE A W Hedrick			

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4365

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 04338

Item 12 FilmG182 5-31-55 et

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>		LENGTH OF STAY (in this place) <u>2 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Glen Arm</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove St. Hosp.</u>				STREET ADDRESS (If rural give location) <u>Box 294-C Harford Rd.</u>			
3. NAME OF DECEASED: (First) <u>BRUNO</u> (Middle) <u>Bernard</u> (Last) <u>Anton</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>5</u> <u>17</u> <u>1955</u>			
5. SEX: <u>M.</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u></u>	8. DATE OF BIRTH: <u>Oct 6th 1874</u>	9. AGE last birthday: <u>80</u> yrs.	IF UNDER 1 YEAR: Months <u></u> Days <u></u>	IF UNDER 24 HRS.: Hours <u></u> Min. <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardener</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>landscape gardener</u>		11. BIRTHPLACE (State or foreign country): <u>Germany</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME: <u>BRUNO Bosse</u>				14. MOTHER'S MAIDEN NAME: <u>JOSANNA</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>9</u>				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT & ADDRESS: <u>MRS. Mary Benhoff - same</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>450.0</u>							
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Bronchiopneumonia</u>						<u>5 days</u>	
(B) <u>Advanced arteriosclerosis</u>						<u>unknown</u>	
(C) <u></u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Extreme Debility.</u>							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3</u> <u>17</u> , 19 <u>55</u> , to <u>5</u> <u>17</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5</u> <u>17</u> , 19 <u>55</u> , and that death occurred at <u>11:10</u> <u>PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Bertold J. Fleischmann</u>		M. D. <u>Spring Grove St. Hosp.</u>		DATE SIGNED <u>5. 17. 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/21/55</u>		NAME OF CEMETERY OR CREMATORY <u>Sacred Heart</u>		LOCATION (City, town, or county) (State) <u>Balto Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-18-55</u>		REGISTRAR'S SIGNATURE <u>aw Hedrick</u>		24. FUNERAL DIRECTOR <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford</u>	

UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

1781

RECEIVED
BUREAU OF LAND MANAGEMENT
U.S. DEPARTMENT OF THE INTERIOR
WASHINGTON, D.C.

4366

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Balto.	
CITY (If outside corporate limits, write RURAL OR TOWN) 55 Rural: Towson		LENGTH OF STAY (in this place) 17 yrs 10 mths. dys.		CITY (If outside corporate limits, write RURAL OR TOWN) Baltimore		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 01 Eudowood Sanatorium Towson 4, Maryland				STREET ADDRESS (If rural give location) 1615 Rickenbacker Road		1	
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
(Type or Print) Dorothy Ellis Breon				5 18 1955			
5. SEX: Female		6. COLOR OR RACE: white		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married		8. DATE OF BIRTH: March 1, 1916	
				9. AGE last birthday: 39 yrs		yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife				10b. KIND OF BUSINESS OR INDUSTRY: Homemaking		11. BIRTHPLACE (State or foreign country): DuBois, Penn.	
13. FATHER'S NAME: Alonzo D. Weaver				12. CITIZEN OF WHAT COUNTRY? U.S.A			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) 3 no				16. SOCIAL SECURITY No.: 176-10-0639		17. INFORMANT & ADDRESS: Personal History Hospital Records, Eudowood Sanatorium	

18. MEDICAL CERTIFICATION				Interval Between Onset And Death	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
002X Immediate cause (a) Pneumonia, Tuberculosis. 64+10 mos					
Antecedent causes (s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO					
(c)					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION: 0				19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) SUICIDE HOMICIDE				20. AUTOPSY: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 12-31, 1948, to 5/18, 1955, that I last saw the deceased alive on 5/18, 1955, and that death occurred at 6:15 PM, from the causes and on the date stated above.					
SIGNATURE Mabel C. Gray		(Degree or title)		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (Specify) Removal		DATE THEREOF May 19, 1955		NAME OF CEMETERY OR CREMATORY Eudowood Sanatorium - Towson 4, Maryland	
DATE REC'D BY LOCAL REGISTRAR May 19, 1955		REGISTRAR'S SIGNATURE Mabel C. Gray		24. FUNERAL DIRECTOR John Burns' Sons, Towson, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

MAY 20 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

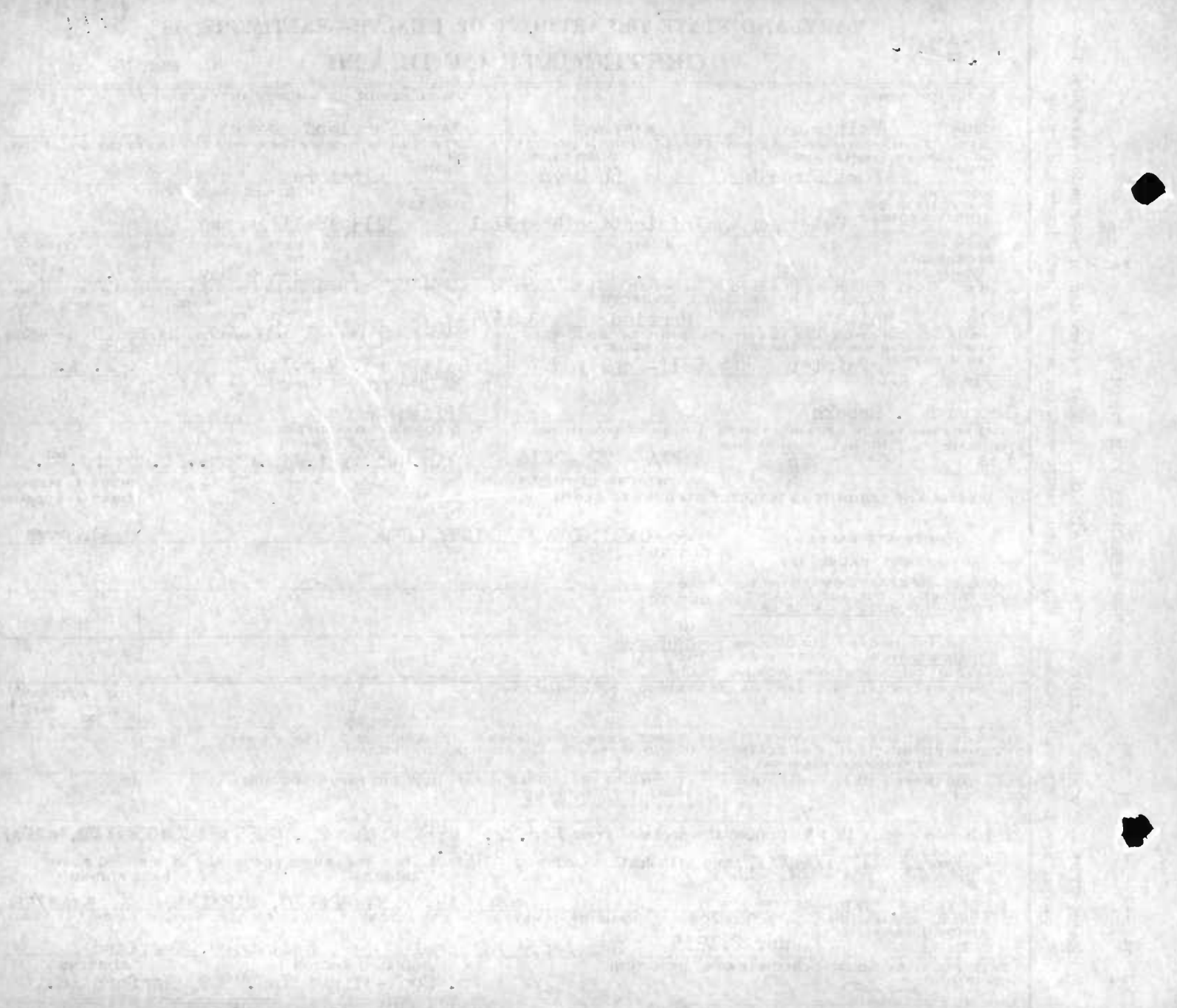
04340

4367

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Fort Howard</u>		<u>68 Days</u>		OR TOWN <u>Baltimore</u> <u>3V01-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		<u>Veterans Administration Hospital</u>		STREET ADDRESS (If rural give location)			
<u>50</u>				<u>3213 Abell Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: (Type or Print) <u>OLIVER M. BROOKS</u>				OF DEATH: <u>May 29, 19 55</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>3/16/93</u>	
9. AGE last birthday: <u>62 yrs.</u>		IF UNDER 1 YEAR: Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Painter</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>	
		10b. KIND OF BUSINESS OR INDUSTRY: <u>Self-Employed</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME: <u>Leonard V. Brooks</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth Cook</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>WW I</u>				16. SOCIAL SECURITY NO. <u>214 - 22 -2018</u>		17. INFORMANT & ADDRESS: <u>Clin.Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>CARCINOMA OF RIGHT LUNG</u>						Unknown	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>2</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21c. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>VA</u> <u>M.</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar. 22, 1955</u> to <u>May 29, 19 55</u> and that death occurred at <u>8:00 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>WILLIAM B. VANDEGRIFT, M.D.</u>				ADDRESS <u>M. D. VAH, FORT HOWARD, MARYLAND</u> DATE SIGNED <u>5/30/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 2, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6-1-55</u>		REGISTRAR'S SIGNATURE <u>A. W. [Signature]</u>		24. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook-Blight Inc. 6009 Harford Rd., Baltimore 14, Maryland</u>			



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04341

4368

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE		MARYLAND		STATE MD.		COUNTY ANNE ARUNDEL	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 52 CATONSVILLE		LENGTH OF STAY (in this place) SINCE 1/7/49		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ANNAPOLIS 02-10-2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 14 SPRING-GROVE				STREET ADDRESS (If rural give location) 45 MADISON AVE ✓			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH:			
BENJAMIN B. BROWN				5 8 1955			
5. SEX: M	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W	8. DATE OF BIRTH: 6/6/78	9. AGE last birthday: 76 yrs	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PLASTERER		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): MD -		12. CITIZEN OF WHAT COUNTRY: U.S.A.	
13. FATHER'S NAME: Robert W. Brown				14. MOTHER'S MAIDEN NAME: ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service): 4 No				16. SOCIAL SECURITY NO. —		17. INFORMANT & ADDRESS: HOSPITAL RECORDS	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) 493X PNEUMONIA						2 WKS	
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B)							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. EPILEPSY, ARTERIOSCLEROSIS						YEARS	
19A. DATE OF OPERATION: 0 —		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg, etc.		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1/7/49 , 19... to 5/8/55 , 19..., that I last saw the deceased alive on 5/8/55 , 19..., and that death occurred at 1504 , M. from the causes and on the date stated above.							
SIGNATURE Charles W. Wald M.D.		M. D.		ADDRESS Spring Grove Hosp.		DATE SIGNED 5/8/55	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		5-10-55		St Annes Cemt		Annapolis Md	
DATE REC'D BY LOCAL REGISTRAR May 9, 1955		REGISTRAR'S SIGNATURE Victor E. Harry		24. FUNERAL DIRECTOR		ADDRESS John W. Taylor Sons Annapolis Md	

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MAY 12 1955

BUREAU V. 8

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4369

CERTIFICATE OF DEATH

Reg. Dist. No.

04342

38

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR	
TOWN <u>Baltimore</u>	<u>12</u>	TOWN <u>Baltimore</u>	<u>3V01-4</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>90</u> <u>Armecost Nursing Home</u>		<u>Wyman Park Apts.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
<u>WALTER B. CALLOWAY</u>		<u>May 13, 1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>male</u>	<u>white</u>	<u>widowed</u>	<u>Dec. 28, 1873</u>
9. AGE last birthday		10. BIRTHPLACE (State or foreign country):	
<u>81</u> yrs.		<u>Ohio</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Ohio</u>			
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Thomas Bond Calloway</u>		<u>Anna Bowles</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>No</u>		<u>no</u>	
17. INFORMANT & ADDRESS:			
<u>Mr. A. B. Calloway - Wyman Park Apts.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<u>493X</u>		<u>4 days</u>	
IMMEDIATE CAUSE (A)			
<u>Pneumonia</u>			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(B)			
DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
<u>Cerebral Vascular accident</u>		<u>2 yrs</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>0</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>8/23/49</u> , to <u>5/13/55</u> , that I last saw the deceased alive on <u>5/12/55</u> , 19 <u>55</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above.			
SIGNATURE		ADDRESS	
<u>Francis W. Glueck</u>		<u>100 W University Pkwy</u>	
M. D.		DATE SIGNED	
<u>5/14/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>Burial</u>		<u>5/16/55</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Glen Forest Cem.</u>		<u>Harrison, Ohio</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
<u>May 14 1955</u>		<u>R.W.</u>	
FUNERAL DIRECTOR		ADDRESS	
<u>Thos. J. Dickner & Sons - Balto</u>		<u>17</u>	

STATE OF NEW YORK

IN SENATE

January 1, 1901

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1900

ALBANY:

JOHN W. BAKER, PRINTERS

1901

STATE OF NEW YORK

IN SENATE

January 1, 1901

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1900

ALBANY:

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January 1, 1901

REPORT

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FOR THE YEAR 1900

ALBANY:

JOHN W. BAKER, PRINTERS

1901

STATE OF NEW YORK

IN SENATE

January 1, 1901

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4370

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04343

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>md.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>521 Calverville</u>		LENGTH OF STAY (in this place) <u>14 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore 15</u> <u>3401-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove Stab Hosp</u>				STREET ADDRESS (If rural give location) <u>4106 Newbern Ave</u>			
3. NAME OF DECEASED: (Type or Print) <u>Eda</u> (First) (Middle) (Last) <u>Coplan</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>5-9-1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Unknown</u>	9. AGE last birthday <u>44</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Mr. Samuel Coplan - 4106 Newbern</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>422.1</u>							
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Cerebrovascular Accident</u>							
DUE TO							
(B) <u>Arteriosclerotic cardiovascular disease</u>						<u>Years</u>	
DUE TO							
(C) <u>Generalized arteriosclerosis</u>						<u>Years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9.26</u> , 19 <u>55</u> , to <u>5.9</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5.8</u> , 19 <u>55</u> , and that death occurred at <u>1:15 AM</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Gertrude J. Fleischmann</u>		M. D. <u>Spring Grove Hosp 5.9.1955</u>		DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-10-55</u>		NAME OF CEMETERY OR CREMATORY <u>Rosedale</u>		LOCATION R. or town, or county) (State) <u>Balto Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/9/55</u>		REGISTRAR'S SIGNATURE <u>V.E. Harry</u>		24. FUNERAL DIRECTOR <u>Jack Lewincke</u>		ADDRESS <u>2100 Cutlers Pl</u>	

BUREAU V. S.

MAY 10 1965

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4371

CERTIFICATE OF DEATH

Reg. Dist. No.

04344

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
<u>Oliver Beach</u>		<u>3 Mos.</u>		<u>Oliver Beach</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Gunpowder Rd.</u>				STREET ADDRESS (If rural give location) <u>Gunpowder Rd.</u>			
3. NAME OF DECEASED: (First) <u>BESSIE</u> (Middle) <u>M.</u> (Last) <u>CASSELL</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>May 19 1955</u>			
5. SEX: <u>F.</u>		6. COLOR OR RACE: <u>W.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>May 12, 1888</u>	
9. AGE last birthday <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>--</u>		11. BIRTHPLACE (State or foreign country): <u>Md.</u>	
13. FATHER'S NAME: <u>Albert Elsroad</u>				14. MOTHER'S MAIDEN NAME: <u>Victoria Hahn</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS: <u>Miller B. Cassell Oliver Beach, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>CEREBRAL HEMORRHAGE</u>						<u>3 DAYS</u>	
ANTECEDENT CAUSE (S) <u>CEREBRAL INJURY - Accident Nov. 1954</u>						<u>6 Mo</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>(260X)</u>							
(C) <u>DIABETES MELLITUS</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>MAR., 1955</u> , to <u>MAY 19, 1955</u> , that I last saw the deceased alive on <u>May 19, 1955</u> , and that death occurred at <u>1 P. M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Louis Lemmon</u>		ADDRESS <u>M. D. 1437 Tunney Ave. Balt. Md.</u>		DATE SIGNED <u>5/19/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-22-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Oliver</u>		LOCATION (City, town, or county) (State) <u>Frederick, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-20-55</u>		REGISTRAR'S SIGNATURE <u>G. W. Hedrick</u>		24. FUNERAL DIRECTOR <u>M. R. Etchison & Son</u>		ADDRESS <u>Frederick, Md.</u>	

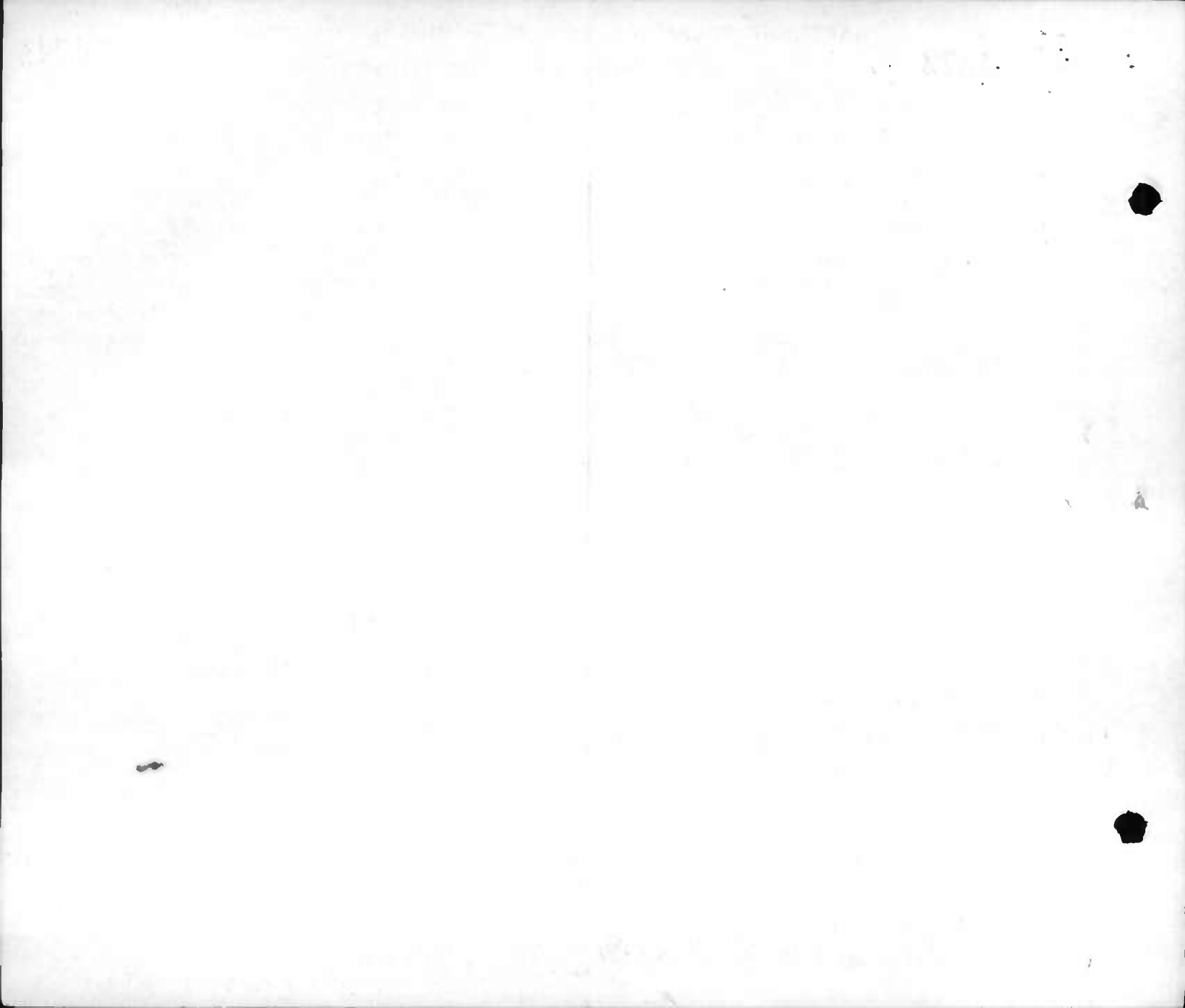
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MD</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>PARKVILLE</u>		LENGTH OF STAY (in this place) <u>2 years</u>		CITY (If outside corporate limits, write RURAL OR TOWN) <u>PARKVILLE</u>		COUNTY	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7834 DANIEL AVE</u>				STREET ADDRESS (If rural give location) <u>7834 DANIEL AVE</u>			
3. NAME OF DECEASED: (First) <u>Theodore</u> (Middle) (Last) <u>CHOP</u>				4. DATE OF DEATH: (Month) <u>May</u> (Day) <u>25</u> (Year) <u>1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>JAN 23 - 1916</u>	9. AGE last birthday: <u>39</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired. <u>ELECTRONICS Tech</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Bendix Radio</u>		11. BIRTHPLACE (State or foreign country): <u>PENN</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>FRANK CHOP</u>				14. MOTHER'S MAIDEN NAME: <u>MARY ZNIDARSK</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unks) <u>Yes</u>		16. SOCIAL SECURITY No.: <u>172-03-2586</u>		17. INFORMANT & ADDRESS: <u>M Dolores Chop 7834 DANIEL AVE</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				Interval Between Onset And Death			
Immediate cause (a) <u>Acute Myocarditis with Cong.</u>				<u>6 mos.</u>			
Antecedent causes (s) (b) <u>Cardiac Hypertrophy</u>				<u>12 mos.</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>Malignant Hypertension</u>				<u>15 mos.</u>			
11. OTHER SIGNIFICANT CONDITIONS				<u>Idiopathic Hypertension</u>			
Conditions contributing to the death but not related to the disease or condition causing death.				<u>7 yrs.</u>			
19a. DATE OF OPERATION: <u>None</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 24</u> , 19 <u>55</u> , to <u>May 25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 24</u> , 19 <u>55</u> , and that death occurred at <u>8:20 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Frank G. Kwik, M.D.</u>		ADDRESS <u>9005 Harford Rd Balto 14</u>		DATE SIGNED <u>5/25/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>May 30 1955</u>		NAME OF CEMETERY OR CREMATORY <u>JOHNSTOWN</u>		(State) <u>PENN</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-26-55</u>		REGISTRAR'S SIGNATURE <u>W.A. Hedra</u>		24. FUNERAL DIRECTOR <u>Chas. F. Evans & Son</u>		ADDRESS <u>8802 HARFORD RD</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

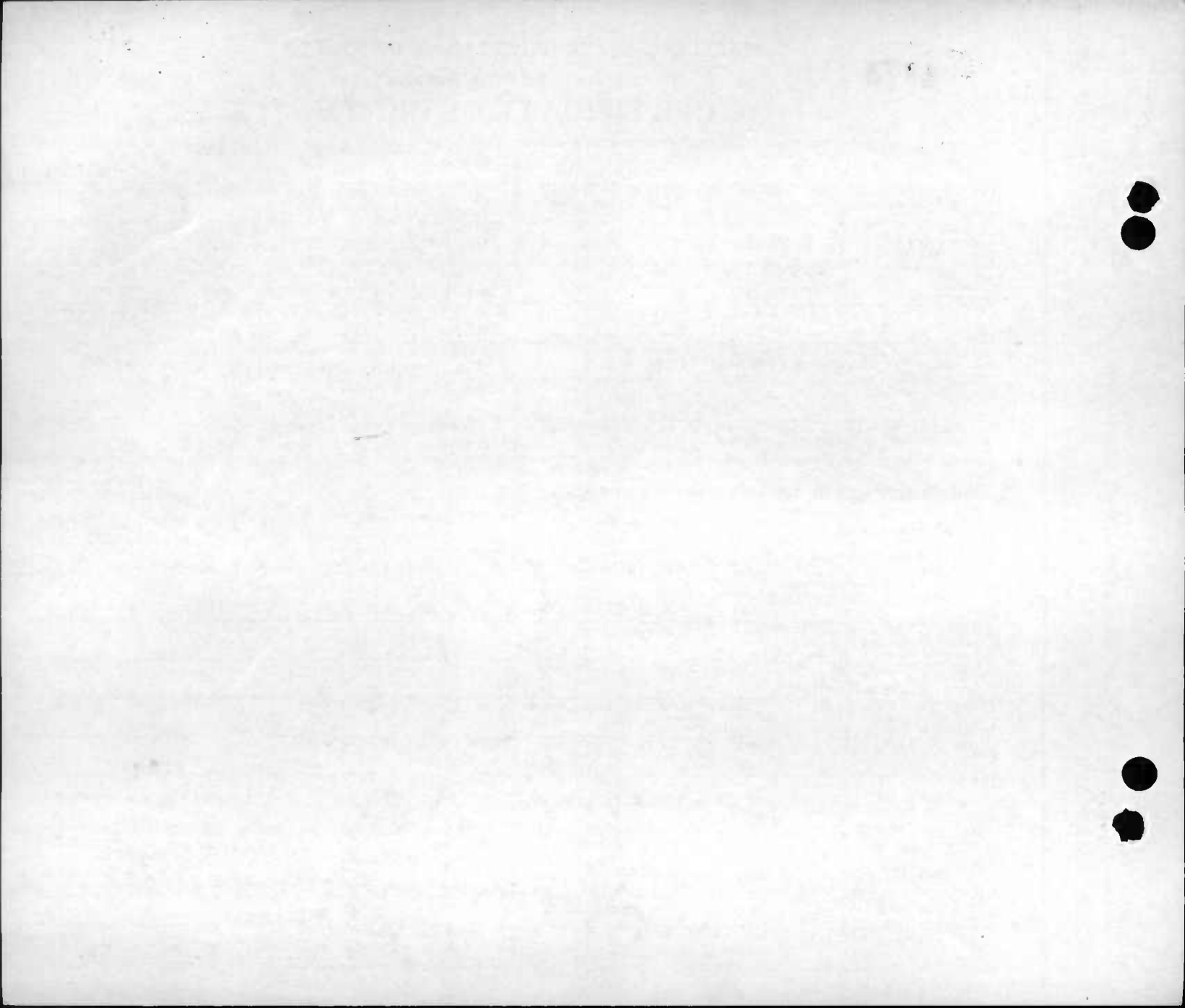
CERTIFICATE OF DEATH

Reg. Dist. No. 30

4373

04346

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
TOWN <u>Catonsville</u>		TOWN <u>Catonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Catonsville Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>315 Ingelside Ave.</u>	
3. NAME OF DECEASED (First) <u>Charles</u> (Middle) <u>A.</u> (Last) <u>Christ</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>29</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct. 27, 1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pipe Fitter</u>	9. AGE last birthday <u>62</u> yrs. If under 1 year Months <u> </u> Days <u> </u> If under 24 hrs. Hours <u> </u> Min. <u> </u>
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>John Christ</u>		14. MOTHER'S MAIDEN NAME <u>Amelia Stevens</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY No. <u>213-01-4736</u>	
17. INFORMANT AND ADDRESS <u>Mrs Anna Woelfer 577 47th Street</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>422.1</u> Immediate cause <u>Chronic Myocardial Degeneration</u> Antecedent cause(s) <u>Arteriosclerotic Cardiovascular Disease</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Parkinson's Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year.</u> <u>3 yrs.</u> <u>6 yrs.</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>no operation</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u> <u>HOMICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u> </u> (CITY OR TOWN) <u> </u> (COUNTY) <u> </u> (STATE) <u> </u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u> </u> m. <u> </u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR? <u> </u>			
22. I hereby certify that I attended the deceased from <u>June 23, 1953</u> , to <u>May 29, 1955</u> , that I last saw the deceased alive on <u>May 23, 1955</u> , and that death occurred at <u>5 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Joshua H. Armacost M.D.</u>		ADDRESS <u>6419 Windsor Mill Rd Baltimore Md</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>June 1, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Schwartz</u>		LOCATION (City, town, or county) <u>Baltimore</u> (State) <u> </u>	
24. FUNERAL DIRECTOR <u>Lilly & Zeiler Inc., 403 S. Wolfe St.</u>		ADDRESS <u> </u>	
DATE REC'D BY LOCAL REG. <u>5-31-55</u>		REGISTRAR'S SIGNATURE <u>A. W. Hedgich</u>	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04347

4374

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Charles</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>52 Catonsville</u>		LENGTH OF STAY (in this place) <u>4 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Welcome</u> <u>08X-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove State Hospital</u>				STREET ADDRESS (If rural give location) <u>✓</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>William Brent Clements</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>May 4, 19 55</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>8-27-1874</u>	9. AGE last birthday: <u>80</u> yrs	IF UNDER 1 YEAR: Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Blacksmith</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Alonzo</u>				14. MOTHER'S MAIDEN NAME: <u>Mary A. Richardson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hospital</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE		(A) <u>Chronic nephritis</u>				Years	
ANTECEDENT CAUSE (S)		(B)					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Banti's Syndrome</u>						Years	
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-30-</u> , 19 <u>55</u> to <u>5-4-</u> , 19 <u>55</u> that I last saw the deceased alive on <u>5-4-</u> , 19 <u>55</u> , and that death occurred at <u>9:20AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Spring Grove State Hosp</u>		ADDRESS <u>Catonsville 28, Md.</u>		DATE SIGNED <u>5-4-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-7-55</u>		NAME OF CEMETERY OR CREMATORY <u>St Charles Cemetery</u>		LOCATION (City, town, or county) (State) <u>Glymont, Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/6/55</u>		REGISTRAR'S SIGNATURE <u>Jahia H. [Signature]</u>		24. FUNERAL DIRECTOR <u>Hunt & Ryan</u>		ADDRESS <u>Waldorf, Md</u>	

RECEIVED
MAY 9 1955
BUREAU V. S.

4375

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. 04348

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balls</u>		MARYLAND		STATE <u>md</u> COUNTY <u>Balls</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Calverton</u>		LENGTH OF STAY (in this place) <u>10-24-53</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Baltimore</u>		TOWN <u>Calverton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove Hosp</u>				STREET ADDRESS (If rural, give location) <u>111 W Symington Ave</u>			
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>Katherine Ruth Coates</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>5 7 1953</u>			
5. SEX: <u>7</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>W</u>		8. DATE OF BIRTH: <u>9-13-73</u>	
9. AGE last birthday: <u>81</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>		11. BIRTHPLACE (State or foreign country): <u>md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME: <u>AMOS Ames Ruth</u>			
14. MOTHER'S MAIDEN NAME: <u>Marion L Shaw</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>4 no</u>			
16. SOCIAL SECURITY No.: <u>1010 Leadon</u>				17. INFORMANT & ADDRESS: <u>Hosp Records</u>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
903.7 Immediate cause (a) DUE TO <u>Acute Cardiac failure</u>					
Antecedent cause(s) (b) DUE TO <u>Terminal Pneumonia</u>					
Diseases or conditions, if any, giving rise to the above cause, stating underlying cause last (c) <u>fracture left hip</u>					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION: <u>May 5 53</u>		19b. MAJOR FINDING OF OPERATION: <u>Operation Hip & fracture corrected by pin</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg, etc., INJURY <u>Hospital</u>		21c. (City or town) (County) (State) <u>Calverton Balls md</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>3 24 53</u> M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>fall on floor</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>Dr McKieffer</u>		1010 Leadon		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>5-8-53</u>	
		M. D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>5/11/55</u>		NAME OF CEMETERY OR CREMATORY <u>Grace Church</u>	
LOCATION (City, town, or county) (State) <u>Elkridge, Howard Co</u>		24. FUNERAL DIRECTOR <u>Wm. H. H. & Son</u>		ADDRESS	
DATE REC'D BY LOCAL REG. <u>5/10/55</u>		REGISTRAR'S SIGNATURE <u>V.C. Harry</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 12 1965

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1804349

4376

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore	MARYLAND	STATE Maryland	COUNTY Baltimore
CITY (If outside corporate limits, write RURAL OR and give nearest town) Towson	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 158 Dumbarton Road		STREET ADDRESS (If rural give location) 158 Dumbarton Road #12	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) Mr. Benjamin F. Collier	(Middle) F.	(Last) Collier	OF DEATH: May 31st 1955
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed	8. DATE OF BIRTH: Sept. 22, 1888
9. AGE last birthday 66 yrs.		10. BIRTHPLACE (State or foreign country): Virginia	
11. CITIZEN OF WHAT COUNTRY? USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Mr. Charles H. Collier		14. MOTHER'S MAIDEN NAME: Catherine V. Coats	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-01-0999	
17. INFORMANT & ADDRESS: Mrs. Gustav Klein, 158 Dumbarton Road #12			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Concussion of cerebryum from 1/3 92			
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: April 15 54		19B. MAJOR FINDINGS OF OPERATION: As above	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from May 30, 1955 , to May 31, 1955 , that I last saw the deceased alive on May 30, 1955 , and that death occurred at 10 A. M. , from the causes and on the date stated above.			
SIGNATURE Henry J. H. D.		DATE SIGNED May 31, 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial		DATE THEREOF June 3, 1955	
NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		LOCATION (City, town, or county) (State) Baltimore, Maryland	
DATE REC'D BY LOCAL REGISTRAR 6-1-55		REGISTRAR'S SIGNATURE R. W. H. G. H. G.	
24. FUNERAL DIRECTOR Leonard J. Ruck, 5305 Harford Road #14		ADDRESS	

Dr. Haase

4218 Harford

M

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

04350

Reg. Dist. No. 35

4377

1. PLACE OF DEATH COUNTY <u>Baltimore.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Parkton.</u> OR TOWN <u>Parkton.</u> LENGTH OF STAY (in this place) <u>62 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Parkton</u> OR TOWN <u>Parkton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rayville Rd.</u>		STREET ADDRESS (If rural, give location) <u>Rayville Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>HARRY CLIFTON COOPER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 13 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>July 26, 1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm.</u>	9. AGE last birthday <u>62</u> yrs. If under 1 year Months Days If under 24 hrs Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Parkton Md. R.D. 1</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Cooper.</u>		14. MOTHER'S MAIDEN NAME <u>Clara Armacost.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u> </u>	
17. INFORMANT AND ADDRESS <u>Mrs. Sydney Cotter, Parkton, Md.</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
4201 Immediate cause (a) <u>Coronary occlusion</u>		
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION <u>0</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION OR REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>May 16, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Pine Grove EUB Cemetery</u>	LOCATION (City, town, or county) (State) <u>Parkton Balto. Co. Md.</u>
DATE REC'D BY LOCAL REG. <u>May 14 1955</u>	REGISTRAR'S SIGNATURE <u>Charles J. Eudon</u>	24. FUNERAL DIRECTOR <u>Jacob Hartenstein</u>	ADDRESS <u>Now Freedom, Pa.</u>

MARGIN RESERVED FOR BINDING

VS. A15A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 27 1955

RECEIVED

THIS IS A PERMANENT RECORD.
PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.
Every item of information so carefully supplied. Physicians: please write the causes of death clearly and leg
THIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

4378

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2, film 181 5-20-55 et

CERTIFICATE OF DEATH

Reg. Dist. No.

0435130

1. NAME OF DECEASED (Type or Print) <u>JANE Cooper</u>			2. DATE OF DEATH <u>5/12/55</u>		
3. PLACE OF DEATH: A. Baltimore <u>City</u> , Maryland <u>BALTIMORE</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Scranton PA</u> B. COUNTY <u>Scranton PA</u>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>52 Catonsville</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>BALTO. (Catonsville)</u>		
D. STREET ADDRESS (If rural, give location) <u>516 Maiden Choice Lane</u>			5. SEX <u>Female</u>		
c. Length of stay in Baltimore <u>3 weeks</u>			6. COLOR OR RACE <u>White</u>		
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>			8. DATE OF BIRTH <u>1892</u>		
9. AGE (In years, last birthday) <u>63</u>			10. AGE (In years, last birthday) <u>5</u> Months <u>18</u> Days <u>18</u> Hours <u>Min.</u>		
11. BIRTHPLACE (State or foreign country) <u>Scranton PA</u>			12. CITIZEN OF WHAT COUNTRY? <u>PA</u>		
13. FATHER'S NAME <u>David Hughes</u>			14. MOTHER'S MAIDEN NAME <u>Susan White</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Y</u>			16. SOCIAL SECURITY NO. <u>204-12-3811</u>		
17. INFORMANT <u>Thomas Cooper</u>			ADDRESS <u>516 Maiden Choice Lane</u>		
18. <u>174x</u> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Pulmonary Embolism</u>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <u>General Circumstances</u>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Chronic of Throat</u>					
19A. DATE OF OPERATION <u>5/12</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>General Circumstances</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>5/12</u>		21B. HOW DID INJURY OCCUR? <u>General Circumstances</u>		21C. HOW DID INJURY OCCUR? <u>General Circumstances</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>5/12</u> 19 <u>55</u> , that (I) (we) last saw the deceased alive on <u>5/12</u> 19 <u>55</u> , and that death occurred at <u>8:15</u> a.m., from the causes and on the date stated above.					
23A. SIGNATURE <u>James H. Heston</u>		23B. ADDRESS <u>4123 Frederick Ave</u>		23C. DATE SIGNED <u>5/13/55</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>5/16/55</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Scranton PA</u>	
24D. LOCATION (City, town, or county) <u>BALTIMORE</u>		24E. LOCATION (City, town, or county) <u>BALTIMORE</u>		24F. LOCATION (City, town, or county) <u>BALTIMORE</u>	
25. FUNERAL DIRECTOR <u>Thomas J. Kennedy</u>		ADDRESS <u>1600 Hollins St</u>		25. FUNERAL DIRECTOR <u>Thomas J. Kennedy</u>	

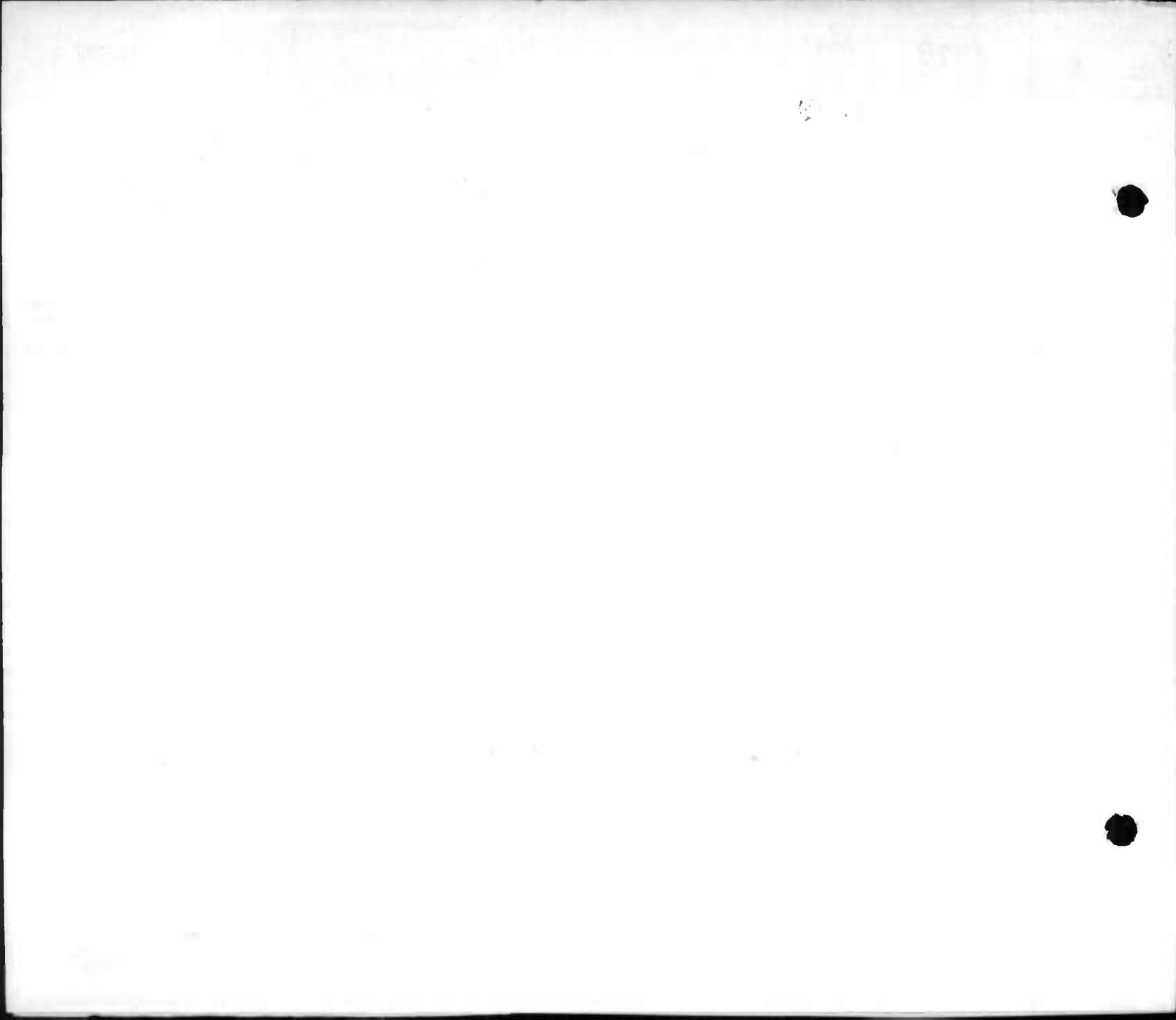
ML CERTIFICATION

DATE RECEIVED BY LOCAL REGISTRAR
5-13-55

REGISTRAR'S SIGNATURE
W. H. Heston

25. FUNERAL DIRECTOR
Thomas J. Kennedy

ADDRESS
1600 Hollins St



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04352

4379

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH- COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>	
TOWN <u>Overlea</u>		TOWN <u>Overlea</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>30 E Elm Ave</u>		STREET ADDRESS (If rural, give location) <u>30 E Elm Ave</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<u>Anna Catherine Copeland</u>		<u>May 7 1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 12-1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	9. AGE last birthday <u>71</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Balto City md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Stein</u>		14. MOTHER'S MAIDEN NAME <u>Helen Hammel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Mr. S. P. Copeland, 30 E Elm Ave</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause 420.1

(a) Coronary Occlusion

INTERVAL BETWEEN ONSET AND DEATH Sudden

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerotic Cardiovascular disease

4 yrs

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>HOMICIDE</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan. 1, 1955, to March 7, 1955, that I last saw the deceased

alive on 5/7, 1955, and that death occurred at 11:30 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL, (Specify) <u>Burial</u>	DATE THEREOF <u>5/11/55</u>	NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem</u>	LOCATION (City, town, or county) <u>Balto md</u>	(State)
DATE REC'D BY LOCAL REG. <u>May 9, 1955</u>	REGISTRAR'S SIGNATURE <u>Ans. M. E. Reifneider</u>	24. FUNERAL DIRECTOR <u>Lassman Funeral Home</u>	ADDRESS <u>7401 Belair Rd</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr Baungardner
phila Rd

BUREAU V. S.

MAY 12 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04353

CERTIFICATE OF DEATH

Reg. Dist. No. *12*

4350

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY BALTIMORE	MARYLAND	STATE MARYLAND	COUNTY Baltimore
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN FORT HOWARD	3 HRS. 40 MIN.	TOWN BALTIMORE	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL		STREET ADDRESS (If rural give location) 8219 BELAIR ROAD	
3. NAME OF DECEASED: (Type or Print)		4. DATE (Month) (Day) (Year)	
SILAS A. DANIELS		DEATH: MAY 11 19 55	
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): MARRIED	8. DATE OF BIRTH: 5-14-95
9. AGE last birthday 59 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): WATCHMAN		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): CULPEPPER, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME: JAMES DANIELS		14. MOTHER'S MAIDEN NAME: ELIZA MN: UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) YES (If Yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 212-20-8030	
17. INFORMANT & ADDRESS: CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MD.			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1			
IMMEDIATE CAUSE		(A) OLD MYOCARDIAL INFARCTS, LEFT VENTRICLE	
ANTECEDENT CAUSE (S)		DUE TO CORONARY ARTERIOSCLEROSIS WITH THROMBOSIS	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) DUE TO	
		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 2		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? 10:50 A.M. 2:30 P.M.	
22. I hereby certify that I attended the deceased from MAY 11 , 19 55 , to MAY 11 , 19 55 , that I last saw the deceased on MAY 11 , 19 55 , and that death occurred at 2:30 P.M. , from the causes and on the date stated above.			
SIGNATURE William B. VandeGrift, M.D.		ADDRESS M. D. VAH, FORT HOWARD, MARYLAND	
DATE SIGNED 5-12-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF MAY 14, 1955	
NAME OF CEMETERY OR CREMATORY VILLA MARIA CEMETERY		LOCATION (City, town, or county) (State) BALTIMORE (TOWSON) MARYLAND	
DATE REC'D BY LOCAL REGISTRAR 5-13-55		REGISTRAR'S SIGNATURE W. B. VandeGrift	
24. FUNERAL DIRECTOR Wm. Cook-Blight, Inc. Funeral Home		ADDRESS 6909 Harford Road, Baltimore 14, Md.	

STATE OF NEW YORK
IN SENATE
January 1, 1907.
REPORT
OF THE
COMMISSIONER OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1906.
ALBANY:
J. B. LEECH, STATE PRINTER.
1907.

MARYLAND STATE DEPARTMENT OF HEALTH

04354

4343

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

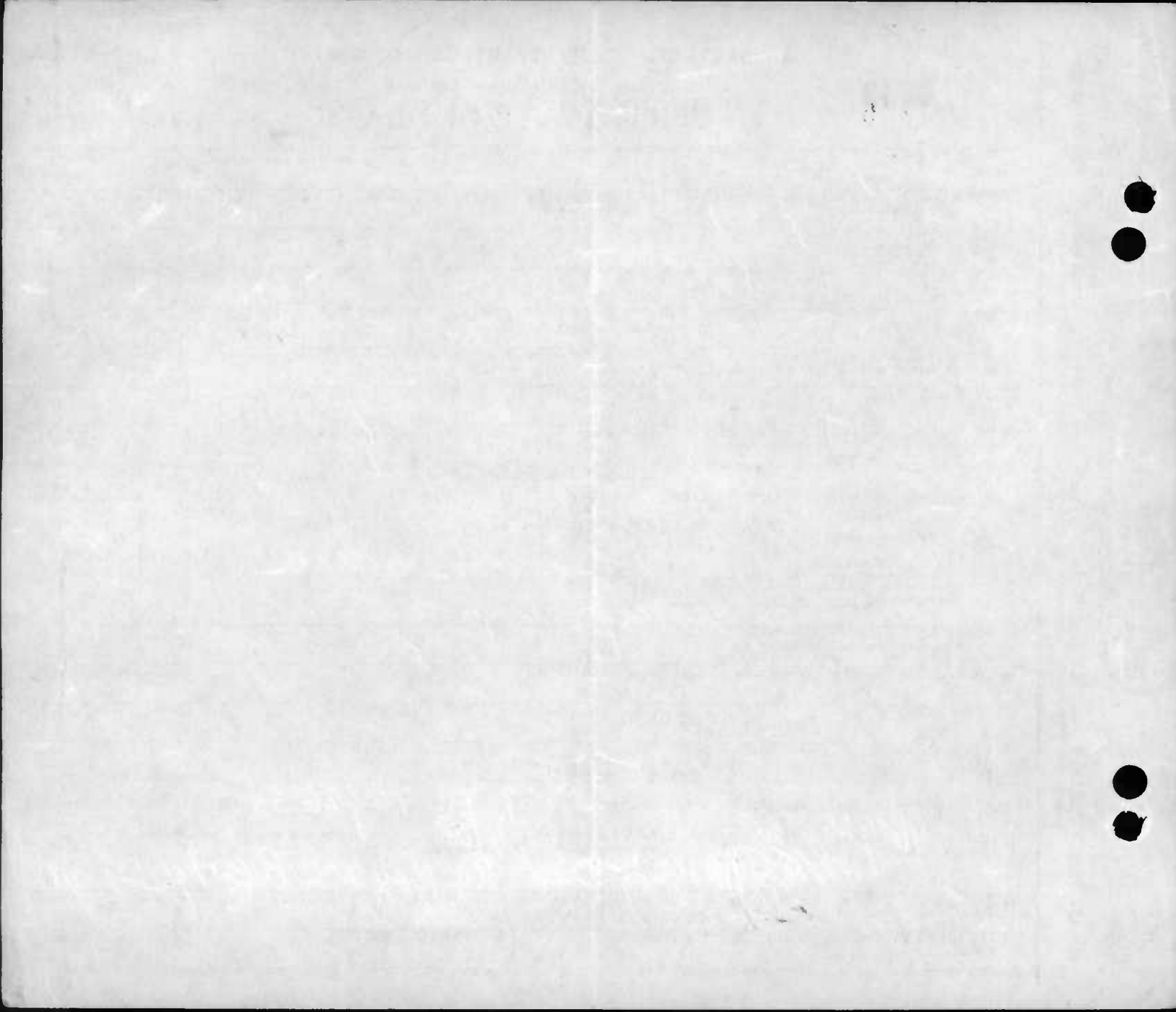
Reg. Dist. No. 42

1. PLACE OF DEATH- COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTO</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTO</u>	
TOWN <u>BALTO</u>		TOWN <u>BALTO</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>CRADDOCK CONVALESCENT</u>		STREET ADDRESS (If rural, give location) <u>409 N. Wolfe St</u>	
3. NAME OF DECEASED (First) <u>George</u> (Middle) <u>DAVIS</u> (Last)		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>26</u> (Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>9-19-90</u>
9. AGE last birthday <u>64</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>	
11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John DAVIS</u>		14. MOTHER'S MAIDEN NAME <u>FANNIE MEDLEY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES W.W.I</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>FANNIE JOHNSON 409 N. Wolfe St</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
350 X Immediate cause (a) <u>Respiratory Paralysis</u>			
Antecedent cause(s) (b) <u>Perinatal Infection</u>			
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Shaking Palsy</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 29, 1954</u> to <u>May 26, 1955</u> , that I last saw the deceased alive on <u>May 26, 1955</u> , and that death occurred at <u>2:10 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>John N. Williams M.D.</u>		DATE SIGNED <u>May 27, 1955</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>5-31-55</u>	
NAME OF CEMETERY OR CREMATORY <u>BALTO NATIONAL</u>		LOCATION (City, town, or county) (State) <u>5501 FREDERICK AVE</u>	
DATE REC'D BY LOCAL REG. <u>5-31-55</u>		24. FUNERAL DIRECTOR <u>Joseph B. Lock</u> ADDRESS <u>1308 N. Central</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04355

Reg. Dist. No. 45

Item 9. Film 4181 5-19-55 et

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Edgemoor</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Edgemoor</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>2714 Spinnaker Pt 19 mo</u>	
3. NAME OF DECEASED (Type or Print) <u>Rosa Davis</u>		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>10</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>October 14-1878</u> 1/7 76 yrs.
9. AGE last birthday	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>Lawson Throuwer</u>	14. MOTHER'S MAIDEN NAME <u>Unknown</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS <u>Mrs. Clara Goode</u>	18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Broncho pneumonia</u>			<u>10 days</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Arterio sclerosis, Hypertension.</u>			<u>unknown</u>
(c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, or office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>April 29, 1955</u> , to <u>May 10th, 1955</u> , that I last saw the deceased alive on <u>May 10th, 1955</u> , and that death occurred at <u>5:30 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Dr. Thomas M.D.</u>		DATE SIGNED <u>5/10/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Shipped</u>		NAME OF CEMETERY OR CREMATORY <u>Lacross</u>	
DATE RECEIVED BY LOCAL REG. <u>5-12-55</u>		24. FUNERAL DIRECTOR <u>Rayner Sanders</u>	
REGISTRAR'S SIGNATURE <u>W. H. Schull</u>		ADDRESS <u>217 E. Preston St</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04356

4382

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>					
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Notch Cliff near Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Notch Cliff near Towson</u>					
TOWN <u>Notch Cliff near Towson</u>		TOWN <u>Notch Cliff near Towson</u>					
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Villa Maria Glenarm Rd</u>		STREET ADDRESS <u>Glenarm Rd.</u>					
3. NAME OF DECEASED (Type or Print) <u>Sister Mary Praxedes Nick</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>25</u> (Year) <u>1955</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Aug. 28, 1864</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>90</u> yrs. <table border="1"><tr><td>If under 1 year</td><td>If under 24 hrs.</td></tr><tr><td>Months</td><td>Days</td></tr></table>	If under 1 year	If under 24 hrs.	Months	Days
If under 1 year	If under 24 hrs.						
Months	Days						
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>					
13. FATHER'S NAME <u>Peter Nick</u>		14. MOTHER'S MAIDEN NAME <u>Theresa Haines</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No.					
17. INFORMANT AND ADDRESS <u>Sr. Mary Clara Notch Cliff Md.</u>							

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>420.1</u>	(a) <u>Coronary artery disease</u>	<u>2 yrs.</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Hypertensive cardiovascular condition</u>	<u>15 yrs.</u>
(c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April....., 1952., to May 25....., 1955., that I last saw the deceased alive on May 24....., 1955., and that death occurred at 6:00 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

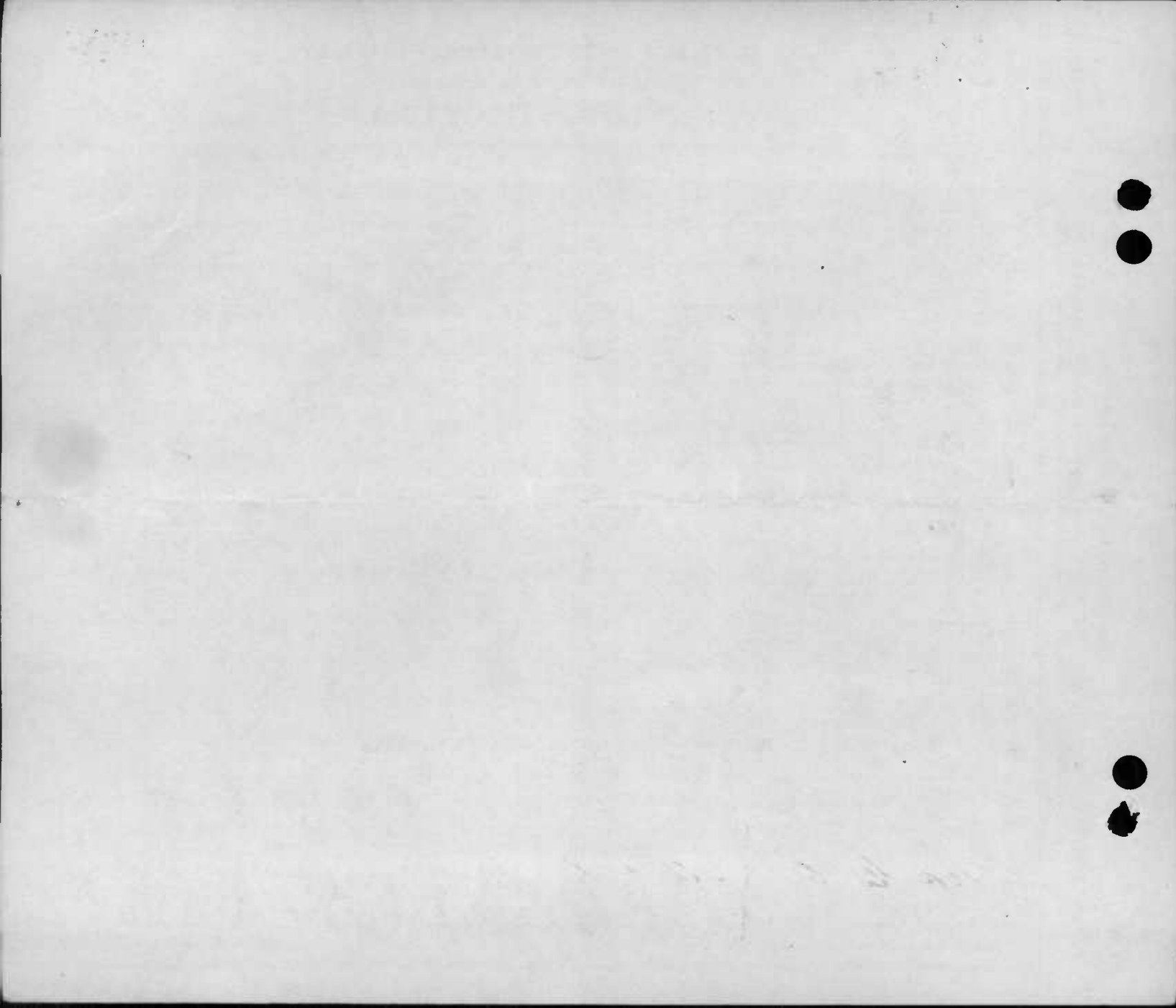
ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVE (Specify) <u>BURIAL</u>	DATE THEREOF <u>5-28-55</u>	NAME OF CEMETERY OR CREMATORY <u>VILLA MARIA CEM., NOTCH CLIFF NR TOWSON, MD.</u>	LOCATION (City, town, or county) (State) <u>BALTO., MD.</u>
DATE REC'D BY LOCAL REG. <u>5-26-55</u>	REGISTRAR'S SIGNATURE <u>Charles J. Gailer</u>	24. FUNERAL DIRECTOR <u>Charles J. Gailer</u>	ADDRESS <u>901 S. CONKLING ST. BALTO., MD.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4383 04357

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTO. CO.</u> MARYLAND	CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>52 CATONSVILLE</u>	STATE <u>MD</u> COUNTY <u>BALTO</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>CATONSVILLE (28) 52</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>114 SMITHWOOD</u>	LENGTH OF STAY (in this place) <u>LIFE</u>	STREET ADDRESS (If rural give location) <u>114 SMITHWOOD AVE</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
<u>ERNEST DIEHLMANN</u>		<u>5/14/55</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH: <u>NOV. 7, 1882</u>
9. AGE last birthday <u>72</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>MD</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Office</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>FREDERICK DIEHLMANN</u>		14. MOTHER'S MAIDEN NAME: <u>ELIZABETH BECKMAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>W 4</u>		16. SOCIAL SECURITY NO. <u>Mr. Cornelia Diehlmann</u>	
17. INFORMANT & ADDRESS:			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Left ventricular failure</u>		<u>12 hrs</u>	
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>ASCVD</u>			
(C) <u>Unknown</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-6</u> , 19 <u>53</u> , to <u>5-14</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-14</u> , 19 <u>55</u> , and that death occurred at <u>1:30</u> P M, from the causes and on the date stated above.			
SIGNATURE <u>Stephen Lee Mackness</u> M.D.		ADDRESS <u>Catonville 28 hd</u> DATE SIGNED <u>5-17-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>5/18/55</u> NAME OF CEMETERY OR CREMATORY <u>40 RRAINE</u> LOCATION (City, town, or county) (State) <u>BALTO. CO.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/18/55</u>		REGISTRAR'S SIGNATURE <u>V.E. Harry</u> 24. FUNERAL DIRECTOR <u>Mac Nabb + Son</u> ADDRESS	

RECEIVED

MAY 19 1967

BUREAU W. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Balto.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <u>Randallstown</u>		OR TOWN <u>Randallstown</u> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Liberty Rd.</u>		STREET ADDRESS (If rural give location) <u>Liberty Rd., Box 229</u>	
3. NAME OF DECEASED: (Type or Print)		4. DATE (Month) (Day) (Year)	
(First) <u>CAROLINE</u> (Middle) <u>DORFFNER</u> (Last)		OF DEATH: <u>May 24 19 55</u>	
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>Dec. 9, 1873</u>
9. AGE last birthday: <u>81</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>--</u>	
11. BIRTHPLACE (State or foreign country): <u>Balto. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Andrew P. Myers</u>		14. MOTHER'S MAIDEN NAME: <u>Annie C. Sauder</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>9-</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Md. Mr. Harvey M. Quimby- Randallstown Box 229</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <u>420.1</u>			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <u>Coronary thrombosis</u>			
DUE TO			
(B) <u>Cardiovascular disease</u>			
DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/24/55</u> , to <u>5/24/55</u> , that I last saw the deceased alive on <u>5/24/55</u> , 19 <u>55</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Dr. E. Martin</u>		ADDRESS <u>Randallstown Md.</u> DATE SIGNED <u>5/24/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>St. Mary's Cem.</u>	
DATE THEREOF <u>5/28/55</u>		LOCATION (City, town, or county) (State) <u>Iloester, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/26/55</u>		REGISTRAR'S SIGNATURE <u>Dr. E. Martin</u>	
FUNERAL DIRECTOR <u>William J. Tiekens</u>		ADDRESS <u>Balto Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 14 1955

BUREAU V. S.

4384

CERTIFICATE OF DEATH

Reg. Dist. No. 04358

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Baltimore</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Baltimore</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Phoenix</i>		LENGTH OF STAY (in this place) <i>47415</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Phoenix</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Phoenix Rd</i>				STREET ADDRESS (If rural, give location) <i>Phoenix Rd</i>			
3. NAME OF DECEASED: (First) (Middle) (Last) <i>Benjamin John DORN</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>May 17 1955</i>			
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH: <i>14 December 1884</i>	9. AGE last birthday <i>70</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>mechanic</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Garage</i>		11. BIRTHPLACE (State or foreign country): <i>Phoenix, Baltimore Md</i>		12. CITIZEN OF WHAT COUNTRY: <i>USA</i>	
13. FATHER'S NAME: <i>John Dorn</i>				14. MOTHER'S MAIDEN NAME: <i>Annie Dorn</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>NO</i>		16. SOCIAL SECURITY No. <i>217-12-9383</i>		17. INFORMANT & ADDRESS: <i>Son - Gilbert Dorn Timonium Md</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Carcinomatosis</i>							
ANTECEDENT CAUSE (S) DUE TO (B) <i>Carcinoma head of Pancreas</i>						over 4 months	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <i>1 Feb. 1955</i>		19B. MAJOR FINDINGS OF OPERATION: <i>Carcinoma Head of Pancreas.</i>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>5/12/1955</i> , to <i>5/12/1955</i> , that I last saw the deceased alive on <i>5/12/1955</i> , and that death occurred at <i>9:50 A</i> M, from the causes and on the date stated above.							
SIGNATURE <i>M. K. Quinn</i>		M. D. <i>TIMONIUM</i>		DATE SIGNED <i>5/17/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>5-20-55</i>		NAME OF CEMETERY OR CREMATORY <i>Chestnut Grove</i>		LOCATION (City, town, or county) (State) <i>Phoenix, Baltimore Md</i>	
DATE REC'D BY LOCAL REGISTRAR <i>20 May 55</i>		REGISTRAR'S SIGNATURE <i>Annie Armistead MacRae</i>		24. FUNERAL DIRECTOR <i>Brooks Funeral Home, Sparks, Md</i>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 23 1955

BUREAU V. S.

4385

MARYLAND STATE DEPARTMENT OF HEALTH

04359

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY Baltimore		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) Timonium		CITY (If outside corporate limits, write RURAL and give nearest town) Timonium	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1838 Locust Ridge Road		STREET ADDRESS (If rural, give location) 1838 Locust Ridge Road	
3. NAME OF DECEASED (Type or Print)	(First) CHARLES	(Middle) CAYWOOD	(Last) DUVALL
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH Feb. 26, 1955
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
13. FATHER'S NAME Robert C. Duvall, Jr.		14. MOTHER'S MAIDEN NAME Marie Gorecki	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) --- (If yes, give war or dates of service) ---		17. INFORMANT AND ADDRESS Dr. Robert C. Duvall, 1838 Locust Ridge Rd.	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 470X Immediate cause (a) Operation of Heart Section Antecedent cause(s) (b) "Cold" Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) ---		Sudden 24 hrs.
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION May 17 1955	19b. MAJOR FINDINGS OF OPERATION Home	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, or office bldg., etc.) Home	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY May 17 1955 5p.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE **Charles T. Donnell MD** (Degree or title) ADDRESS **7501 York Rd.** DATE SIGNED **5/17/55**

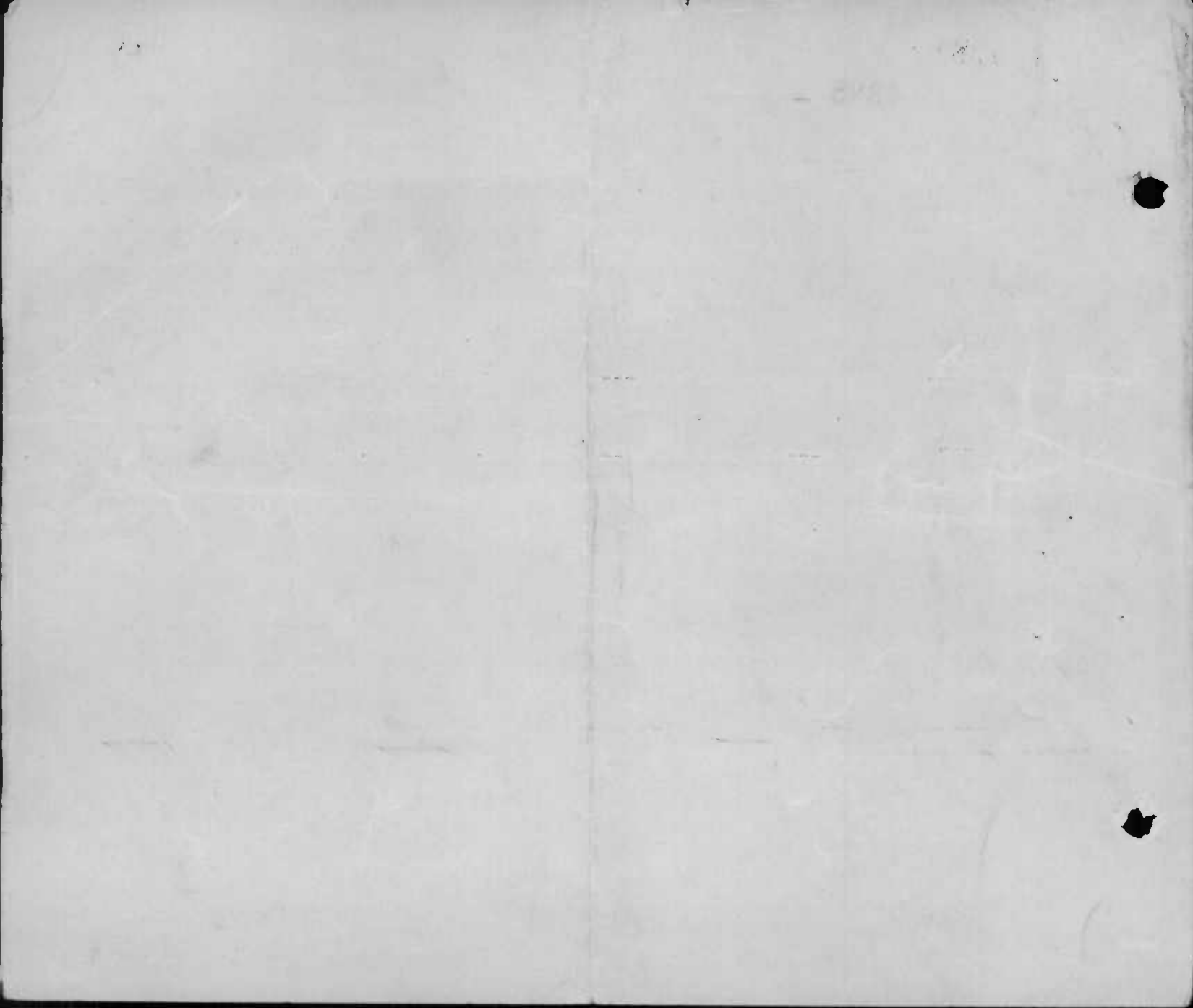
23. REMOVAL (Specify) burial	DATE THEREOF 5/19/55	NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	LOCATION (City, town, or county) Baltimore, Maryland
DATE REC'D BY LOCAL REG. 5-18-55	REGISTRAR'S SIGNATURE A W Pedunk	24. FUNERAL DIRECTOR Wm. Bork, Inc.	ADDRESS 1217 St. Paul Street

202527340

-151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

MAY 27 1955

BUREAU W. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

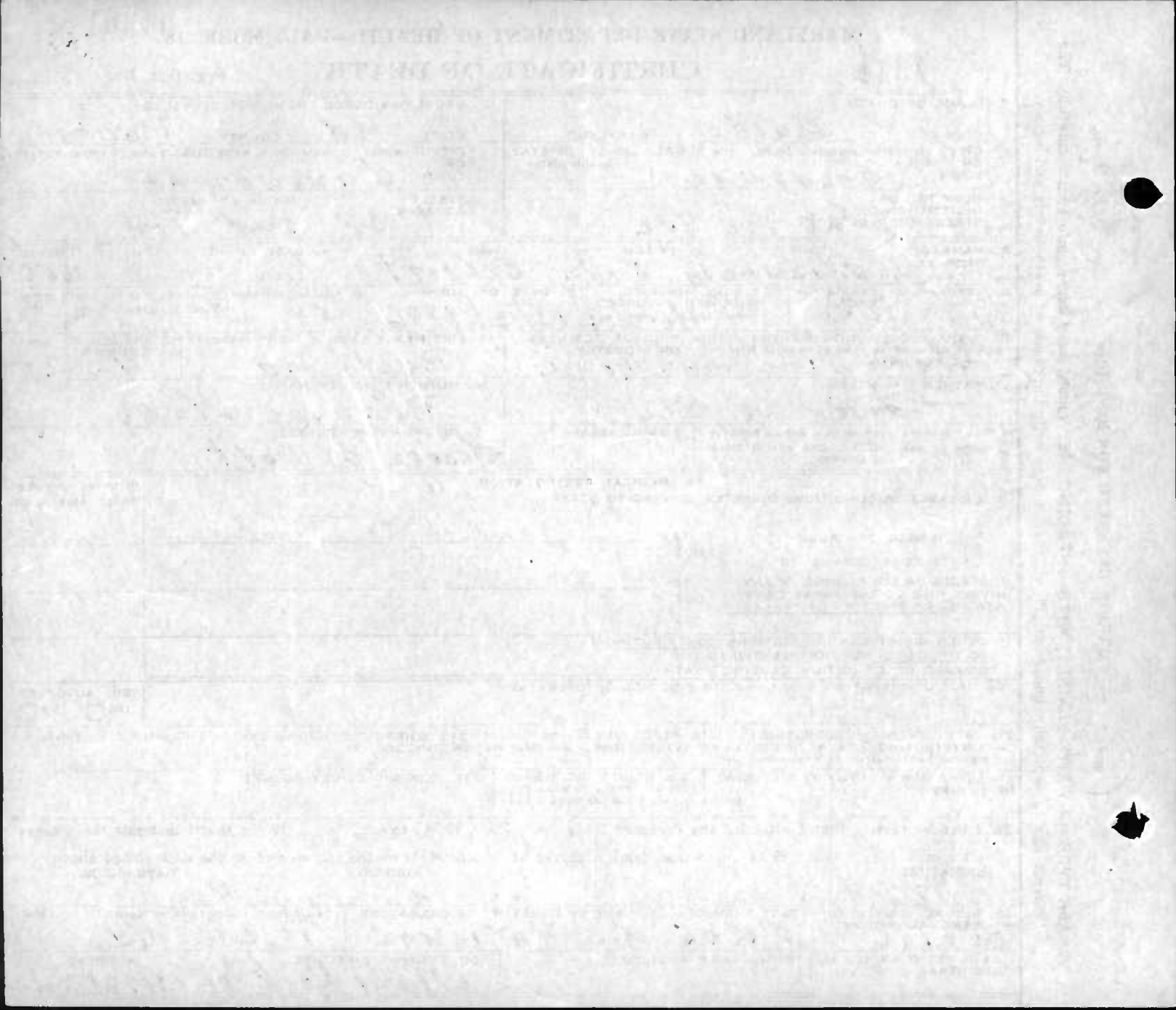
04361

4344

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Balto</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Lansdowne</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Lansdowne</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>28 2nd Ave</u>		STREET ADDRESS (If rural give location) <u>28 2nd Ave</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Elizabeth Ruth Elliott</u>		OF DEATH: <u>May 2 1955</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>12/3/1896</u>
9. AGE last birthday <u>58</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own home</u>	
11. BIRTHPLACE (State or foreign country): <u>Balto. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME: <u>Edwin M. Ely</u>		14. MOTHER'S MAIDEN NAME: <u>Blanche Webb</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>George Elliott</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Carcinoma of the stomach</u>			<u>4-5 months</u>
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			
22. I hereby certify that I attended the deceased from <u>1/2</u> , 1955, to <u>5/1</u> , 1955, that I last saw the deceased alive on <u>5/1</u> , 1955, and that death occurred at <u>11 A.</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Herbert A. Livickas</u>		DATE SIGNED <u>5/3/55</u>	
ADDRESS <u>M.D. 2436 Washington Blvd.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>5/5/55</u>	
NAME OF CEMETERY OR CREMATORY <u>U.S. National</u>		LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-4-55</u>		REGISTRAR'S SIGNATURE <u>William Cook</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>1517 St Paul St</u>	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4387 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04362			
CERTIFICATE OF DEATH			
Reg. Dist. No. 18			
1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY BALTIMORE	MARYLAND	STATE MARYLAND	COUNTY BALTIMORE
CITY (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD	LENGTH OF STAY (in this place) 6 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) BALTIMORE (25)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL	STREET ADDRESS (If rural give location) 5245 4th STREET		
3. NAME OF DECEASED: (First) (Middle) (Last) CHARLES L ENNIS		4. DATE (Month) (Day) (Year) OF DEATH: MAY 20 1955	
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED	8. DATE OF BIRTH: 7/28/86
9. AGE last birthday 68 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): STEAM FITTER		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: JOSEPH ENNIS		14. MOTHER'S MAIDEN NAME: BARBARA ONGLER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) YES WW-I		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT & ADDRESS: CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MD.		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
160X IMMEDIATE CAUSE (A) CARCINOMA OF MAXILLARY SINUS WITH EXTENSION TO RIGHT NECK		2 Years	
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST		(B) DUE TO	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. CIRRHOSIS OF LIVER		Unknown	
19A. DATE OF OPERATION: 2		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from May 14, 1955 , to May 20, 1955 , and that death occurred at 8:04 P M , from the causes and on the date stated above.			
SIGNATURE WILLIAM B. VANDEGRIFT, M.D.		ADDRESS VAH, FORT HOWARD, MD. DATE SIGNED 5/22/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL DATE THEREOF 5/25/55		NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEMETERY LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
DATE REC'D BY LOCAL REGISTRAR 5/23/55		24. FUNERAL DIRECTOR WILLIAM COOK-BLIGHT INC ADDRESS 6009 HARFORD RD BALTO. MD.	

UNITED STATES OF AMERICA

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04363

Reg. Dist. No. 43

Item 14 Film G182 6-6-55 et

1. PLACE OF DEATH- COUNTY Balto MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md COUNTY Balto	
CITY (If outside corporate limits, write RURAL and give nearest town) Fullerton		CITY (If outside corporate limits, write RURAL and give nearest town) Fullerton	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 31 Henry Ave.		STREET ADDRESS (If rural, give location) 31 Henry Ave	
3. NAME OF DECEASED (First) Elmer (Middle) H (Last) Euler	4. DATE OF DEATH (Month) May (Day) 23 (Year) 1955		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH April 25-1905
9. AGE last birthday 50 yrs.		10. If under 1 year Months 5 Days 23 Hours 15 Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Candy Maker		10b. KIND OF BUSINESS OR INDUSTRY Own Business	
11. BIRTHPLACE (State or foreign country) Balto City Md		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Harry Euler		14. MOTHER'S MAIDEN NAME Dena Williams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY No. Mrs Elmer Euler, 31 Henry Ave	
17. INFORMANT AND ADDRESS			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(a) 420.1 Immediate cause Coronary Occlusion - Cardiac Arrest.			minutes
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			12 yrs.
(c) Hypertensive Cardio Vascular Disease.			undetermined.
(d) Nephritis (Nephrosclerosis)			
11. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION 5-23		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at <input type="checkbox"/> Not While <input type="checkbox"/> At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 3-1 , 19 54 , to 5-23 , 19 55 , that I last saw the deceased alive on 5-23 , 19 55 , and that death occurred at 8 p.m. , from the causes and on the date stated above.			
SIGNATURE John C. Kyle M.D.		ADDRESS 7527 Belair Rd Balto 6 Md	
DATE SIGNED 5-24-55			
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF May 26-1955	
NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		LOCATION (City, town, or county) Balto (State) Md.	
DATE REC'D BY LOCAL REG. May 25-55		REGISTRAR'S SIGNATURE Dr. M. B. Reardon	
24. FUNERAL DIRECTOR Lanshan Funeral Home 7401 Belair Rd		ADDRESS	

RECEIVED

MAY 31 1955

BUREAU V. S.

4389

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04364

CERTIFICATE OF DEATH

Reg. Dist. No. 38

Item 4, Film G181 5-17-55 et

1. PLACE OF DEATH: BALTO. COUNTY Towson 4, MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS The Sheppard & Enoch Pratt Hospital Towson 4, Maryland				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Washington, 12, D.C. COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS (If rural give location)											
3. NAME OF DECEASED: (Type or Print) Edith Bentley Farquhar		4. DATE OF DEATH: 5 (Month) 12 (Day) 13 (Year) 1955		5. SEX: Female		6. COLOR OR RACE: white		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widow		8. DATE OF BIRTH: 10/30/66		9. AGE last birthday: 88 yrs. 12 Months 13 Days 13 Hours 13 Min.			
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: housewife				10b. KIND OF BUSINESS OR INDUSTRY:				11. BIRTHPLACE (State or foreign country): Sandy Spring, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME: Edward P. Thomas						14. MOTHER'S MAIDEN NAME: Mary Bentley									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no				16. SOCIAL SECURITY No.:				17. INFORMANT & ADDRESS:							
18. MEDICAL CERTIFICATION												Interval Between Onset And Death			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 451X Immediate cause Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.												(a) RUPTURED ARTERIOSCLEROTIC ANEURYSM DUE TO ABDOMINAL AORTA.		10 MIN	
(b) GENERALIZED ARTERIOSCLEROSIS												5 YEARS			
(c)															
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.															
19a. DATE OF OPERATION: 2												19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) HOMICIDE				PLACE (Home, farm, factory, street, office bldg., etc.) INJURY				(CITY OR TOWN) (COUNTY) (STATE)							
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from May 29, 1951 , to May 13, 1955 , that I last saw the deceased alive on May 12, 1955 , and that death occurred at 1:45 AM from the causes and on the date stated above. SIGNATURE J. M. Elgin, M.D. (Degree or title) ADDRESS Towson, Md DATE SIGNED 5/13/55															
23. BURIAL, CREMATION, REMOVAL (Specify) CREMATION				DATE THEREOF May 14 1955				NAME OF CEMETERY OR CREMATORY FORT LINCOLN				LOCATION (City, town, or county) (State) PRINCE GEORGES CO. MD.			
DATE REC'D BY LOCAL REGISTRAR May 13, 1955				REGISTRAR'S SIGNATURE Mabel C. Gray				24. FUNERAL DIRECTOR Warner E. Humphrey, Inc.				ADDRESS Silver Spring, Md.			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 16 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04365

4390

CERTIFICATE OF DEATH

Reg. Dist. No. 30...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE MARYLAND				STATE MD. COUNTY BALTO.			
CITY (If outside corporate limits, write RURAL OR and give nearest town) 52 CATONSVILLE				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTO. 3V01-4			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 RIDGEWAY MANOR - NURSING HOME, CATONSVILLE				STREET ADDRESS (If rural give location) 5019 FREDERICK RD.			
3. NAME OF DECEASED: (Type or Print) MOLLYE V. FELDT				4. DATE (Month) (Day) (Year) OF DEATH: MAY 21, 1955			
5. SEX: F.	6. COLOR OR RACE: W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED	8. DATE OF BIRTH: AUG. 18, 1886	9. AGE last birthday: 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): H.W.				10B. KIND OF BUSINESS OR INDUSTRY: O.H.		11. BIRTHPLACE (State or foreign country): BALTO. MD.	
13. FATHER'S NAME: CHARLES W. FURY				14. MOTHER'S MAIDEN NAME: ANNA A. LASTNER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: MR. OTTO F. FELDT, 5019 FREDERICK	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH: 1 year	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) 175X Carcinoma, right ovary, with metastasis							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 12-9-54				19B. MAJOR FINDINGS OF OPERATION: Pseudomucinous adenocarcinoma, rt. ovary, with metastasis			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Dec. 15, 1953 , to May 21, 1955 , that I last saw the deceased alive on May 21, 1955 , and that death occurred at 5:20 P.M. from the causes and on the date stated above.							
SIGNATURE John F. Schaefer				M.D. 401 Haddon Road		DATE SIGNED 5/23/55	
23. BURIAL CREMATION, REMOVAL (SPECIFY) BURIAL				DATE THEREOF MAY 24/55		NAME OF CEMETERY OR CREMATORY BALTO. NATIONAL	
LOCATION (City, town, or county) (State) BALTO. MD.							
DATE REC'D BY LOCAL REGISTRAR 3-23-55				REGISTRAR'S SIGNATURE Dr. Hedrick		24. FUNERAL DIRECTOR ADDRESS Harry H. Witzke 4101 EDMONDSON AVE	

MAILED TO SON'S D. BRYAN WENT TO BRYAN'S MOTHER

1 MONTHS LATE ON BEHALF

BALTIMORE MD

BALTIMORE

BALTO

CATONSVILLE

RIDGEWAY MARIAN
NURSING HOME CATONSVILLE

JOHN FREDERICK MD

MAY 21 1972

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UNITED STATES

WILLIAM A. BRYAN

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WILLIAM A. BRYAN

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **04366**
4391 **CERTIFICATE OF DEATH** Reg. Dist. No. **30**

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore	MARYLAND	STATE Maryland	COUNTY —
CITY (If outside corporate limits, write RURAL OR and give nearest town) 52 Catonsville	LENGTH OF STAY (in this place) 22yr11mo8days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 3401.4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 14 Spring Grove State Hospital		STREET ADDRESS (If rural give location) ✓	
3. NAME OF DECEASED: (First) (Middle) (Last) Catherine Finzel		4. DATE (Month) (Day) (Year) OF DEATH May 4, 19 55	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: 1870
9. AGE last birthday 85? yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Maryland
13. FATHER'S NAME: Unknown		14. MOTHER'S MAIDEN NAME: Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT & ADDRESS: Records Spring Grove State Hospital		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) 260X Arteriosclerotic cardiovascular disease		Years	
ANTECEDENT CAUSE (S) (B) Generalized severe arteriosclerosis		Years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Diabetes Mellitus		Years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Debility and Senility		Years	
19A. DATE OF OPERATION: 0	19B. MAJOR FINDINGS OF OPERATION		2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 5-26- , 19 32 to 5-4- , 19 55 that I last saw the deceased alive on 5-4- , 19 55 , and that death occurred at 1:00 PM , from the causes and on the date stated above.			
SIGNATURE S. Wachter		ADDRESS Spring Grove State Hospital DATE SIGNED 5-6-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BORIAL		DATE THEREOF 5/6/55 NAME OF CEMETERY OR CREMATORY SACRED HEART (German) Steel Rd LOCATION (City, town, or county) (State) Catonsville, Md.	
DATE REC'D BY LOCAL REGISTRAR 5/6/55		REGISTRAR'S SIGNATURE V.E. Harry	
24. FUNERAL DIRECTOR J-J Fabeu & Son		ADDRESS 1318 24th St	

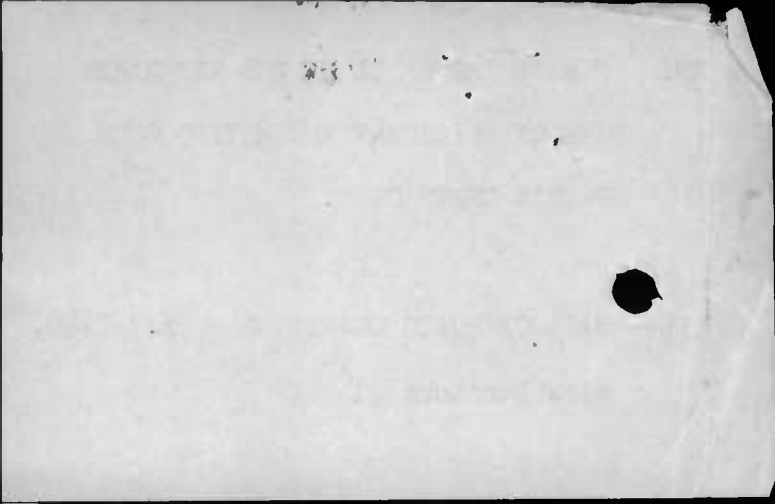
BUREAU V. 2

MAY 9 1955

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NB: PLEASE INFORM LL OF THE ~~INTERMARK~~
NAME, OF APPLICANT REQUESTING COPY
OF THIS DEATH CERT.

(LL(- CALL CATHOLIC CHARITIES * Sa.7-7240,
Miss Varnhorn)



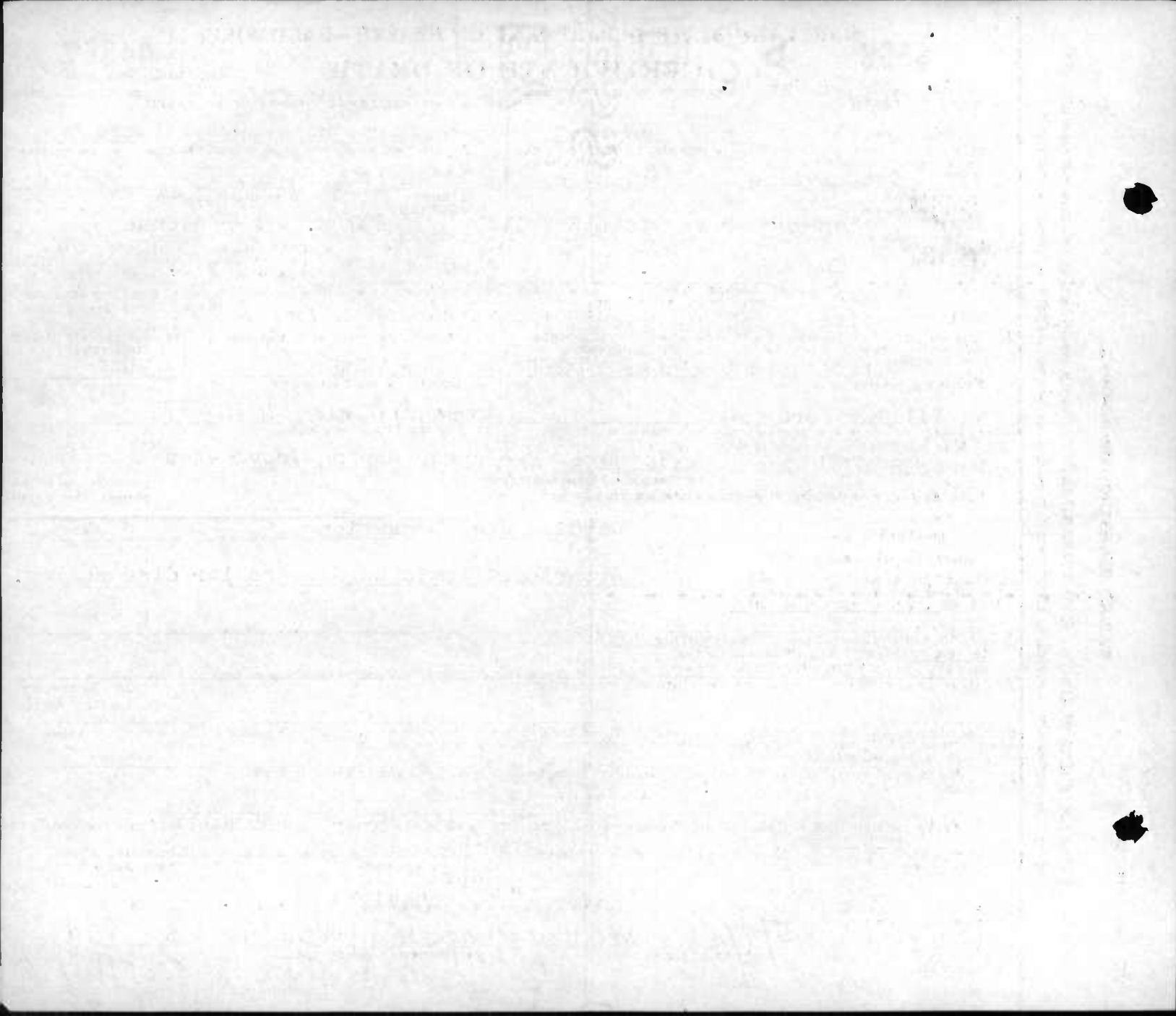
PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4392 CERTIFICATE OF DEATH

04367
Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Catonsville</u>		<u>12 days</u>		OR TOWN <u>Baltimore 14,</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>				STREET ADDRESS (If rural give location) <u>8807 N. Baker Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Eugene W. Ford</u>				<u>May 4, 19 55</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>12-31-1886</u>	
9. AGE last birthday: <u>68</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Stationary Engineer</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>William Ford</u>				14. MOTHER'S MAIDEN NAME: <u>Georgiana Lovett</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>Unknown</u>				16. SOCIAL SECURITY NO. <u>216-10-6379</u>			
17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hospital</u>				18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) <u>422.1 Cardiac decompensation</u>				<u>5 days</u>			
ANTECEDENT CAUSE (S) DUE TO (B) <u>Arteriosclerotic cardiovascular disease Yrs.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-22-</u> , 19 <u>55</u> to <u>5-4-</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-4-</u> , 19 <u>55</u> , and that death occurred at <u>12:45 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>S. Wachter</u>		M. D. <u>Spring Grove State Hosp.</u>		DATE SIGNED <u>5-4-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/7/55</u>		NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>		LOCATION (City, town, or county) (State) <u>Bal To Co - Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-5-55</u>		REGISTRAR'S SIGNATURE <u>a w H...</u>		24. FUNERAL DIRECTOR <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford</u>	



4393

CERTIFICATE OF DEATH

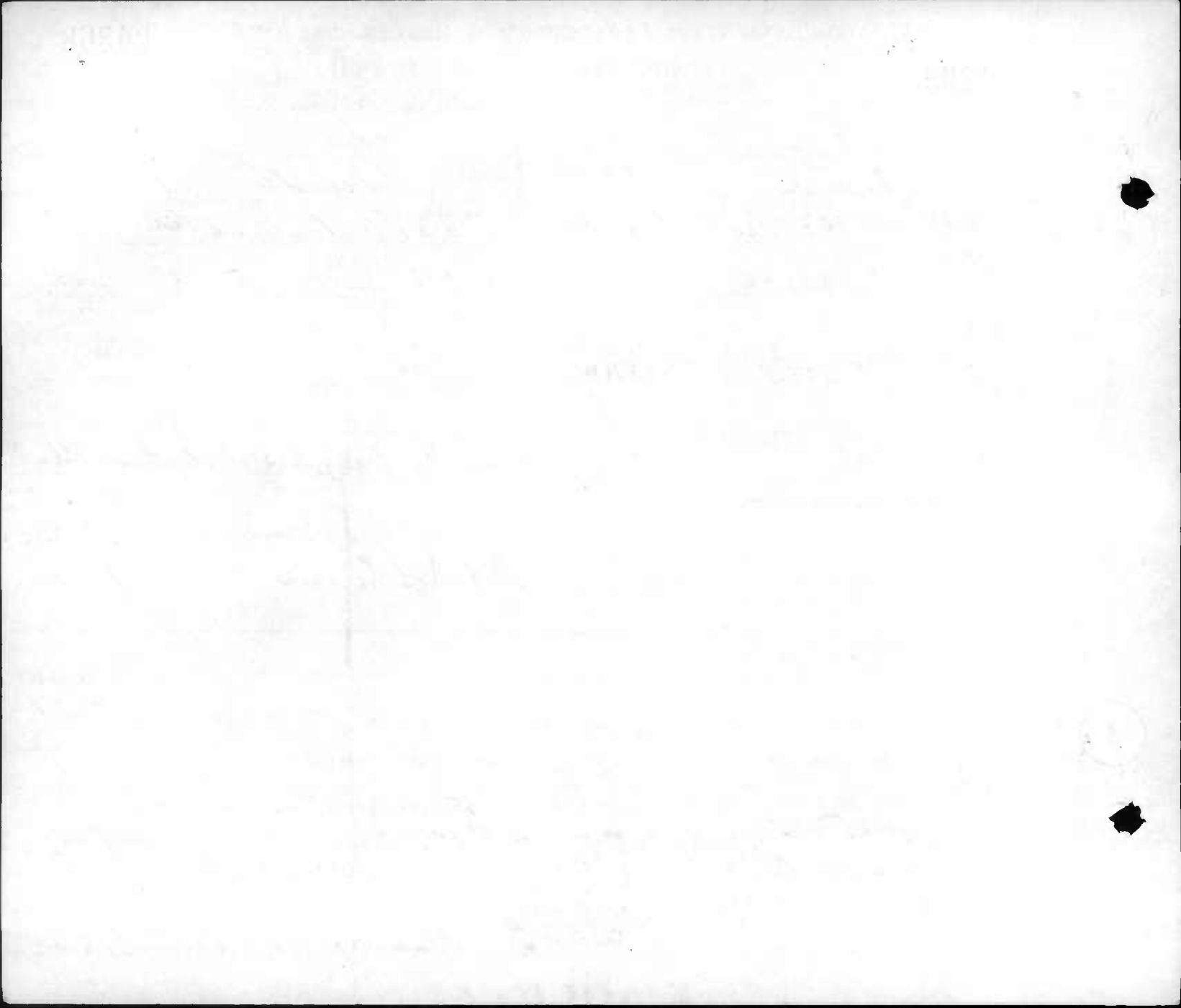
Reg. Dist. No.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Balto</i>		MARYLAND		STATE <i>Md.</i>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Pikesville</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Pikesville</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>107 Reisterstown Rd.</i>				STREET ADDRESS (If rural give location) <i>512 Reisterstown Rd.</i>			
3. NAME OF DECEASED: (First) <i>CHARLES</i> (Middle) <i>L</i> (Last) <i>FREENY</i>				4. DATE OF DEATH: (Month) <i>5</i> (Day) <i>29</i> (Year) <i>1955</i>			
5. SEX: <i>male</i>	6. COLOR OR RACE: <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>married</i>	8. DATE OF BIRTH: <i>Oct 2, 1879</i>	9. AGE last birthday: <i>75</i> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <i>OPERATOR</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>TAVERN</i>		11. BIRTHPLACE (State or foreign country): <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <i>?</i>				14. MOTHER'S MAIDEN NAME: <i>?</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>?</i>		16. SOCIAL SECURITY No.: <i>—</i>		17. INFORMANT & ADDRESS: <i>Mary K. Freeny 512 Reisterstown Rd.</i>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
Immediate cause (a) <i>Coronary Thrombosis</i>						<i>18 hrs.</i>	
Antecedent causes (s) (b) <i>Art. Sclerosis</i>						<i>10 yrs.</i>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <i>0</i>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Jan.</i> , 19 <i>45</i> , to <i>May 29th</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>May 29th</i> , 19 <i>55</i> , and that death occurred at <i>5:30 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>James A. Miller</i>		(Degree or title)		ADDRESS <i>Pikesville 8, Md.</i>		DATE SIGNED <i>5/31/55</i>	
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>6/1/55</i>		NAME OF CEMETERY OR CREMATORY <i>Druid Ridge</i>		LOCATION (City, town, or county) (State) <i>Pikesville Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>6-1-55</i>		REGISTRAR'S SIGNATURE <i>A. W. Hedrick</i>		FUNERAL DIRECTOR <i>Paul E. Schuman</i>		ADDRESS <i>3615-17 Chestnut Ave.</i>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4394

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04369

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE		MARYLAND		STATE MARYLAND		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN FORT HOWARD,		4 Hours 40M.		TOWN BALTIMORE 3V01-4			
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL				STREET ADDRESS (If rural give location) 1037 HOLLINS STREET			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
SOL (NMI) FRIEDMAN				MAY 4 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours Min.
MALE	WHITE	MARRIED	9-22-05	49			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
TAXI DRIVER				BALTIMORE, MARYLAND		U. S. A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
ISAAC FRIEDMAN				ROSE SASS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
YES WW-II		214-03-0115		CLIN.REC., VET.ADM.HOSP., FT. HOWARD, MD.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) SCLERODERMA						6 MONTHS	
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B)							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						3 WEEKS	
PNEUMONIA, RIGHT LOWER LOBE							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
0							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21F. HOW DID INJURY OCCUR?			
VA M.		9: P.M.		1:40 A.M.			
22. I hereby certify that I attended the deceased from MAY 3, 1955 , to MAY 4, 1955 that I last saw the deceased XXXXXX and that death occurred at 1:40 A.M. from the causes and on the date stated above.							
SIGNATURE Francis G. Dickey, M.D., Chief, Medical Service VAH, Fort Howard, Maryland		ADDRESS 5-4-55		DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
BURIAL		May 5/55		Baltimore National		BALTIMORE, MARYLAND	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS			
5-5-55		A W Helms		Sol Levinson & Bros., 1126 W. North Ave. Baltimore, Maryland			
				Sol Levinson & Bros. Inc			

STATE OF NEW YORK
COUNTY OF ALBANY

IN SENATE,
January 1, 1901.

REPORT

OF THE

COMMISSIONERS

OF THE LAND OFFICE

FOR THE YEAR

ENDING DECEMBER

THIRTY, ONE, NINETEEN

HUNDRED AND

ONE.

4395

MARYLAND STATE DEPARTMENT OF HEALTH

04370

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

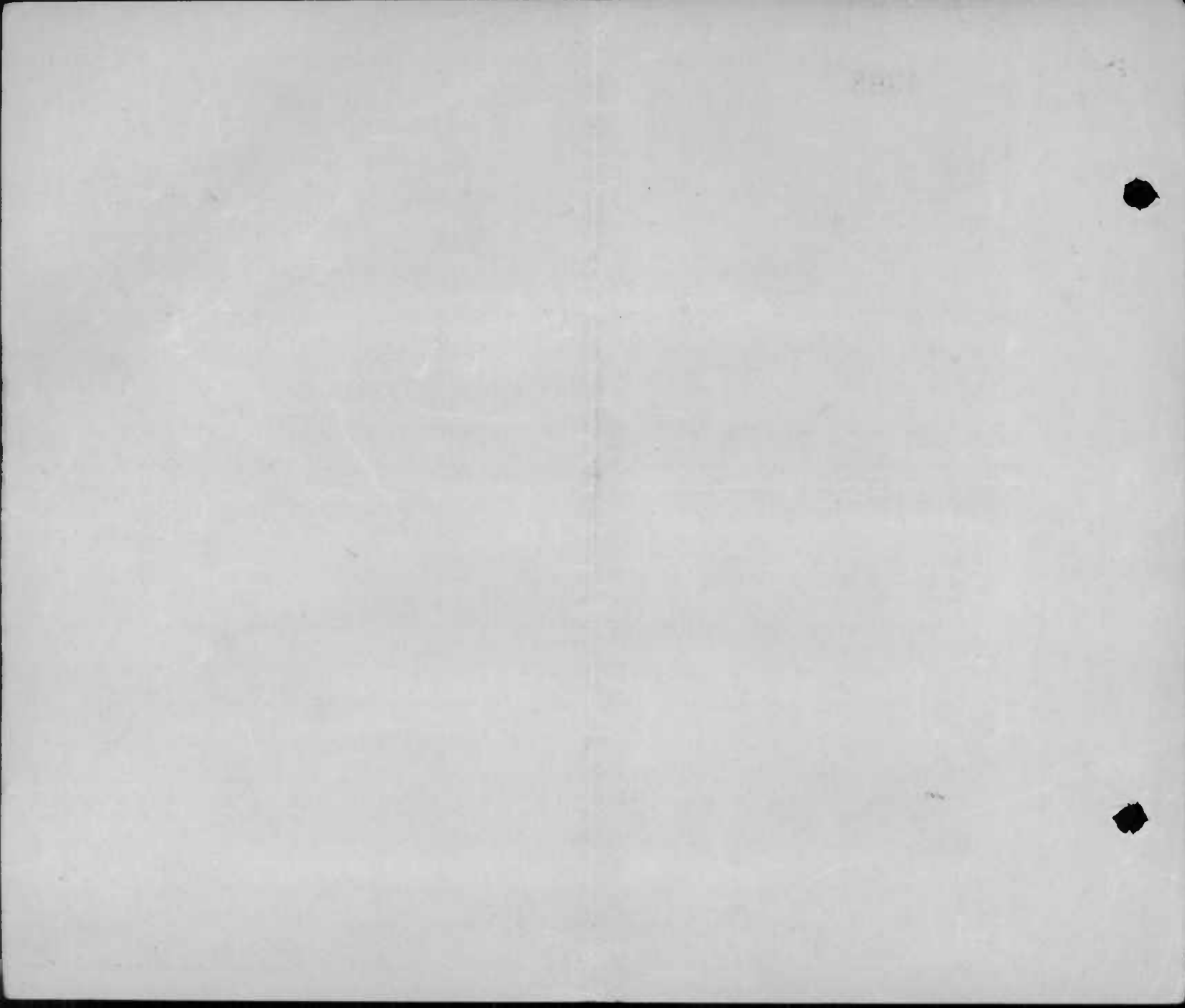
Reg. Dist. No.

Items 13, 14 Film G182 6-17-55 et

1. PLACE OF DEATH - COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Bolts</u>	
X CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>PARKVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7909 WESTMORLAND AVE</u>		STREET ADDRESS (If rural, give location) <u>7909 W. Moreland Ave</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>OTTO</u> (Middle) <u>F</u> (Last) <u>Frubling</u>	4. DATE OF DEATH (Month) <u>May</u> (Day) <u>23</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>FEB. 4, 1886</u>
9. AGE last birthday <u>69</u> yrs.		10. AGE last birthday (If under 1 year) Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>POLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>217-09-8542</u>	
17. INFORMANT AND ADDRESS <u>Charles Frubling Joppa Rd</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
260X Immediate cause (a) <u>Coronary Thrombosis</u>		<u>Sudden</u>	
Antecedent cause(s) (b) <u>Myocardial Degeneration</u>		<u>5 yrs</u>	
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Diabetes Mellitus</u>		<u>10 yrs</u>	
11. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <u>Charles F O'Donnell md</u>		DATE SIGNED <u>7/23/55</u>	
(Degree or title)		ADDRESS <u>2501 York Rd</u>	
23. BURIAL, CREMATION (Specify)		NAME OF CEMETERY OR CREMATORY <u>Holy Rosary Cem.</u>	
DATE THEREOF <u>MAY 26, 1955</u>		LOCATION (City, town, or county) <u>DUNDALK</u>	
24. FUNERAL DIRECTOR <u>John M. Weber</u>		ADDRESS <u>401 S. Chester St</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

4396

CERTIFICATE OF DEATH

Reg. Dist. No. 04371 38

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>	
TOWN <u>PARKVILLE</u>		TOWN <u>PARKVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3007 LAVENDER AVE</u>		STREET ADDRESS (If rural, give location) <u>3007 LAVENDER AVE</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>EDGAR</u>	(Middle) <u>S</u>	(Last) <u>FRY</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <u>MAY 13, 1882</u>
			9. AGE last birthday <u>73</u> yrs. If under 1 year: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PURCHASING AGENT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GOVERNMENT</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>JAMES C. FRY</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA BYRON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS RUTH RICH</u>		<u>3007 LAVENDER AVE</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary Thrombosis</u>			<u>6 week</u>
Antecedent cause(s) (b) <u>11C</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			<u>4 year</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May 17, 1955</u> , to <u>May 17, 1955</u> , that I last saw the deceased alive on <u>May 16, 1955</u> , and that death occurred at <u>10:10 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Harold H Burns</u>		ADDRESS <u>MD 8106 Hartford Rd</u>	
DATE SIGNED <u>May 18, 1955</u>			
23. BURLIN CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>May 20-1955</u>	
NAME OF CEMETERY OR CREMATORY <u>St John Lutheran Church</u>		LOCATION (City, town, or county) <u>Baltimore</u>	
DATE REC'D BY LOCAL REG. <u>5/19/55</u>		REGISTERAR'S SIGNATURE <u>R. M. Bocore</u>	
24. FUNERAL DIRECTOR <u>Chas. F. Evans & Son</u>		ADDRESS <u>8802 Hartford Rd</u>	

RECEIVED

MAY 23 1955

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04372

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Paradise Ave</u>		STREET ADDRESS (If rural, give location) <u>Paradise Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Joseph</u>	(Middle) <u>J.</u>	(Last) <u>Fuller</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	4. DATE OF DEATH (Month) <u>5</u> (Day) <u>12</u> (Year) <u>1955</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	8. DATE OF BIRTH <u>11-17-1873</u>
13. FATHER'S NAME <u>Julius Fuller</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS <u>M's Georgana Watkins Paradise Ave.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>420.1</u>	(a) <u>Coronary Occlusion</u>	<u>Sudden</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Cardio Vascular Disease & Abnormalities</u>	<u>6 months</u>
(c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/12, 1955, to 5/14/55, 1955, that I last saw the deceased alive on 5/10, 1955, and that death occurred at 5:00 P m., from the causes and on the date stated above.

SIGNATURE <u>Elvis W. Johnson</u>	(Degree or title) <u>MD</u>	ADDRESS <u>3632 Madison Ave Baltimore 28 Md</u>	DATE SIGNED <u>5/16/55</u>
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5-17-55</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem</u>	LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
DATE REC'D BY LOCAL REG. <u>5/16/55</u>	REGISTRAR'S SIGNATURE <u>W.E. Harry</u>	24. FUNERAL DIRECTOR <u>Mrs. Frances T. Henneley</u>	ADDRESS <u>Biddle St</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 18 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04373

CERTIFICATE OF DEATH

Reg. Dist. No. 30

4398

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>52 Catonsville</u>		LENGTH OF STAY (In this place) <u>3yrs 27days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>		<u>3y01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove State Hosp</u>				STREET ADDRESS (If rural give location) <u>1012 Roland Heights Ave.</u>			
3. NAME OF DECEASED: (Type or Print) <u>Catherine Fredricka Funk</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>May 1, 1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>Jan. 26, 1872</u>	
9. AGE last birthday: <u>83</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME: <u>August Gernert</u>				14. MOTHER'S MAIDEN NAME: <u>Margaret Hertzberger</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>9 -</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS: <u>Hospital Records</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>420.1 Coronary thrombosis</u>							<u>5 min.</u>
ANTECEDENT CAUSE (S) (B) <u>Terminal cardio-respiratory failure</u>							<u>Several hours</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Generalized arteriosclerosis.</u>							<u>Years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Malnutrition and multiple decubitus ulcers</u>							<u>Months</u>
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 4, 1952</u> , to <u>May 1, 1955</u> , that I last saw the deceased alive on <u>April 30, 1955</u> , and that death occurred at <u>4:55</u> M, from the causes and on the date stated above.							
SIGNATURE <u>John P. Rusley MD.</u>		ADDRESS <u>Spring Grove State Hospital - Catonsville Md.</u>		DATE SIGNED <u>5/1/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/4/55</u>		NAME OF CEMETERY OR CREMATORY <u>mt Olivet</u>		LOCATION (City, town, or county) (State) <u>Freshwater Ave.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/3/55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Paul E. [Signature]</u>		ADDRESS <u>305-17 Blount Ave</u>	



4345

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town) Arbutus LENGTH OF STAY (in this place) 10 yrs.

HOSPITAL OR INSTITUTION OR STREET ADDRESS

4204 Leeds Avenue -29

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MarylandCOUNTY BaltimoreCITY (If outside corporate limits, write RURAL and give nearest town) Arbutus X

STREET ADDRESS

(If rural give location)

4204 Leeds Avenue -29

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

EllaGateman

4. DATE OF DEATH:

(Month)

(Day)

(Year)

May29,19 55

5. SEX:

5. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH:

9. AGE last birthday: 83 yrs.

If UNDER 1 YEAR If UNDER 24 HRS. Months Days Hours Min.

FemaleWhiteApril 1, 187210a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:

Napoleon Peddicord

14. MOTHER'S MAIDEN NAME:

Isabel Stansbury15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) ---16. SOCIAL SECURITY No.: -----

17. INFORMANT & ADDRESS:

Mrs. G. Russell Thomas- 4204 Leeds Avenue, 29

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
Immediate cause(a) Coronary Occlusion

DUE TO

Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.(b) Cardio-vascular Disease

DUE TO

(c)

Interval Between Onset And Death

Sudden

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 26, 1955, to May 29, 1955, that I last saw the deceased alive on May 29, 1955, and that death occurred at 8:45 PM from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED May 29, 1955

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

5-31-55R. W. PeddicordG. Russell Thomas, 4204 Leeds AvenueBalto. 29, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2143

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Handwritten text at the bottom of the page, possibly a date or reference number.

MARYLAND STATE DEPARTMENT OF HEALTH

04375

4399

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

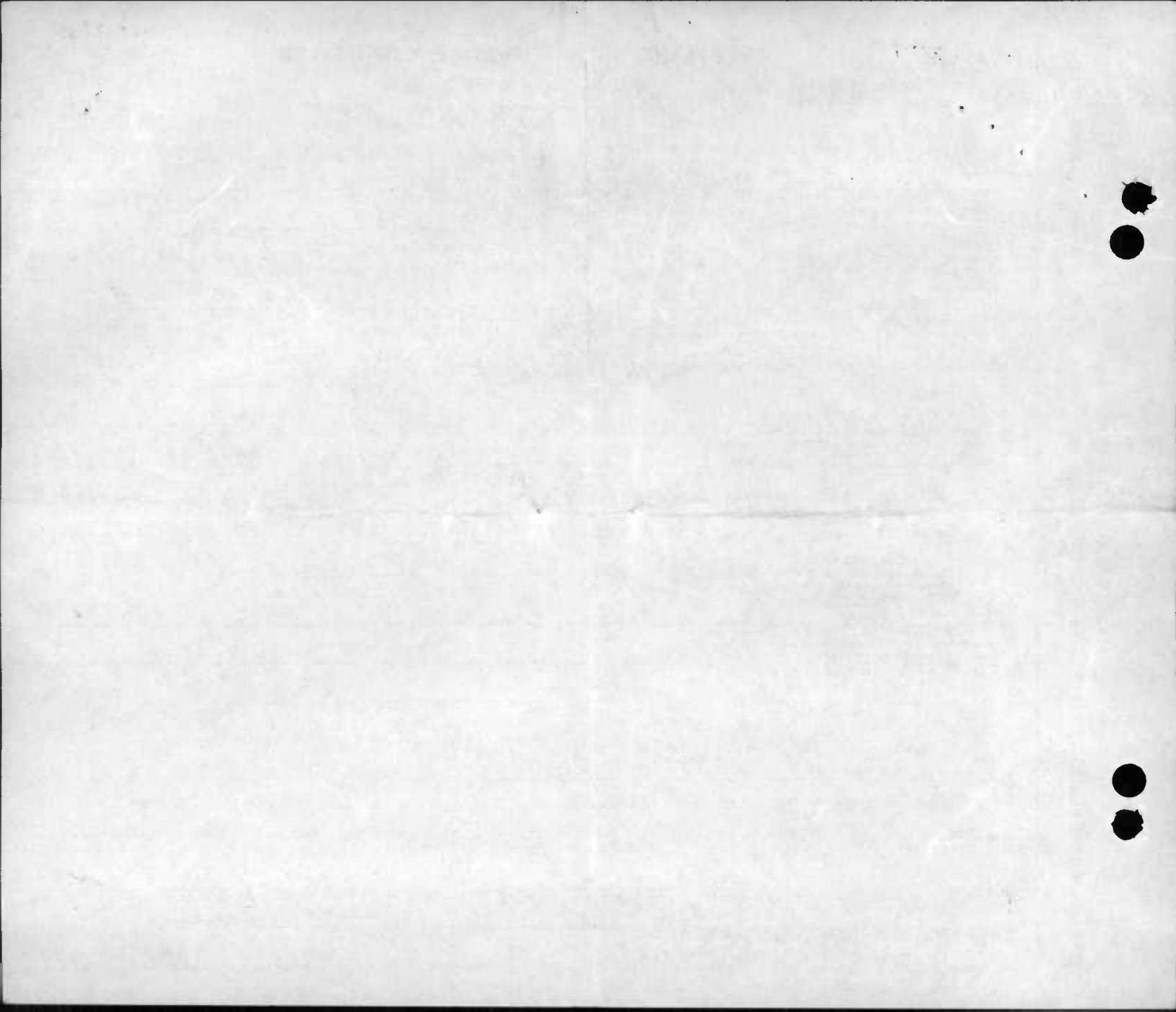
Reg. Dist. No. 30

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House in the Pines H. Home</u>		STREET ADDRESS (If rural, give location) <u>5011 Tupipare - Relay</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Susay</u>	(Middle)	(Last) <u>Heres</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Oct 1-1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	9. AGE last birthday <u>64</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>Austria</u>	
13. FATHER'S NAME <u>Christopher Heres</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Temple</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Dorothy Darch 4113 Hague Ave. Brooklyn.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
260X Immediate cause (a) <u>Hypertensive A.S.C.V.D.</u>			
Antecedent cause(s) (b) <u>Diabetes Mellitus</u>			
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
SUICIDE		INJURY	
HOMICIDE			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Not While Work <input type="checkbox"/> At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>3/2</u> , 19 <u>54</u> , to <u>5/15</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/14</u> , 19 <u>55</u> , and that death occurred at <u>6:45</u> a.m. from the causes and on the date stated above.			
SIGNATURE <u>John C. Healy M.D.</u>		DATE SIGNED <u>5/15/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>5/18/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Ferncliff</u>		LOCATION (City, town, or county) (State) <u>New York City</u>	
DATE REC'D BY LOCAL REG. <u>5-16-55</u>		24. FUNERAL DIRECTOR <u>Cook Inc 1217 St Paul St</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

44-0 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04376

CERTIFICATE OF DEATH

Reg. Dist. No. 45

Item 7, Film 181 5-19-55 at

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Baltimore</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Balto.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Essex</i>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Essex</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <i>23 Pelagias Ave. 21 Md.</i>			
3. NAME OF DECEASED: (Type or Print) <i>Viola Elizabeth Gibson</i>				4. DATE OF DEATH: (Month) (Day) (Year) <i>May 12 1955</i>			
5. SEX: <i>F.</i>		6. COLOR OR RACE: <i>W.</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>		8. DATE OF BIRTH: <i>July 7-1890</i>	
9. AGE last birthday: <i>64</i> yrs.		10. KIND OF BUSINESS OR INDUSTRY: <i>Housewife</i>		11. BIRTHPLACE (State or foreign country): <i>Balto Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				14. MOTHER'S MAIDEN NAME: <i>Mary Christine Hays</i>			
13. FATHER'S NAME: <i>Casper Dressel</i>				17. INFORMANT & ADDRESS: <i>Walter Gibson 23 Pelagias Ave</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <i>No</i>				16. SOCIAL SECURITY NO. <i>—</i>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Cerebral Hemorrhage</i>				5 minutes			
ANTECEDENT CAUSE (S) (B) <i>Mitral Stenosis + Regurgitation</i>				20 years			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>HYPERTENSION</i>				20 years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <i>0</i>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>am</i> , 1955, to <i>May 12</i> , 1955, that I last saw the deceased alive on <i>May 12</i> , 1955, and that death occurred at <i>4 P</i> M, from the causes and on the date stated above.							
SIGNATURE <i>Monis G. Jacob</i>				ADDRESS <i>M. D. 1010 NORTH POINT RD</i> DATE SIGNED <i>May 13-1955</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>5-16-55</i>		NAME OF CEMETERY OR CREMATORY <i>Most Holy Redeemer</i>		LOCATION (City, town, or county) (State) <i>Balto Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>5-13-55</i>		REGISTRAR'S SIGNATURE <i>W. Hedrick</i>		24. FUNERAL DIRECTOR <i>C. Christine Bruzdinski</i>		ADDRESS <i>1407 Eastern Ave</i>	

TO THE DIRECTOR, BUREAU OF INVESTIGATION

FROM THE SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

TO: [Illegible]

FROM: [Illegible]

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

TO: [Illegible]

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RE: [Illegible]

DATE: [Illegible]

TO: [Illegible]

FROM: [Illegible]

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

Item 12, Film G182 6-2-55 et

1. PLACE OF DEATH: COUNTY <u>Balto. Co</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>	
TOWN <u>Dundalk</u>		TOWN <u>Dundalk</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>38 Liberty Parkway</u>		STREET ADDRESS (If rural, give location) <u>38 Liberty Parkway</u>	
3. NAME OF DECEASED (Type or Print) <u>Eleonore</u> (First) <u>Lizynski</u> (Middle) <u>Lizynski</u> (Last)		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>27</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>about 1879</u>
9. AGE last birthday <u>about 75</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Leokadya Koprowski</u>		14. MOTHER'S MAIDEN NAME <u>Maryanna</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Leonard Lizynski 38 Liberty Parkway</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
Immediate cause(a) Coronary Thrombosis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertension Cardio-vascular disease(c) Generalized arterio-sclerosis

INTERVAL BETWEEN ONSET AND DEATH

3 daysII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Sept, 1954 to May 27, 1955, that I last saw the deceased alive on May 27, 1955, and that death occurred at 11:15 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>May 31, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Rosary</u>		LOCATION (City, town, or county) <u>Balto. Co.</u>		STATE <u>Md.</u>	
DATE REC'D BY LOCAL REG. <u>May 28 1955</u>		REGISTRAR'S SIGNATURE <u>R.W.</u>		24. FUNERAL DIRECTOR <u>Wm. S. Fialkowski</u>		ADDRESS <u>2007 Eastern Ave</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Mervy

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

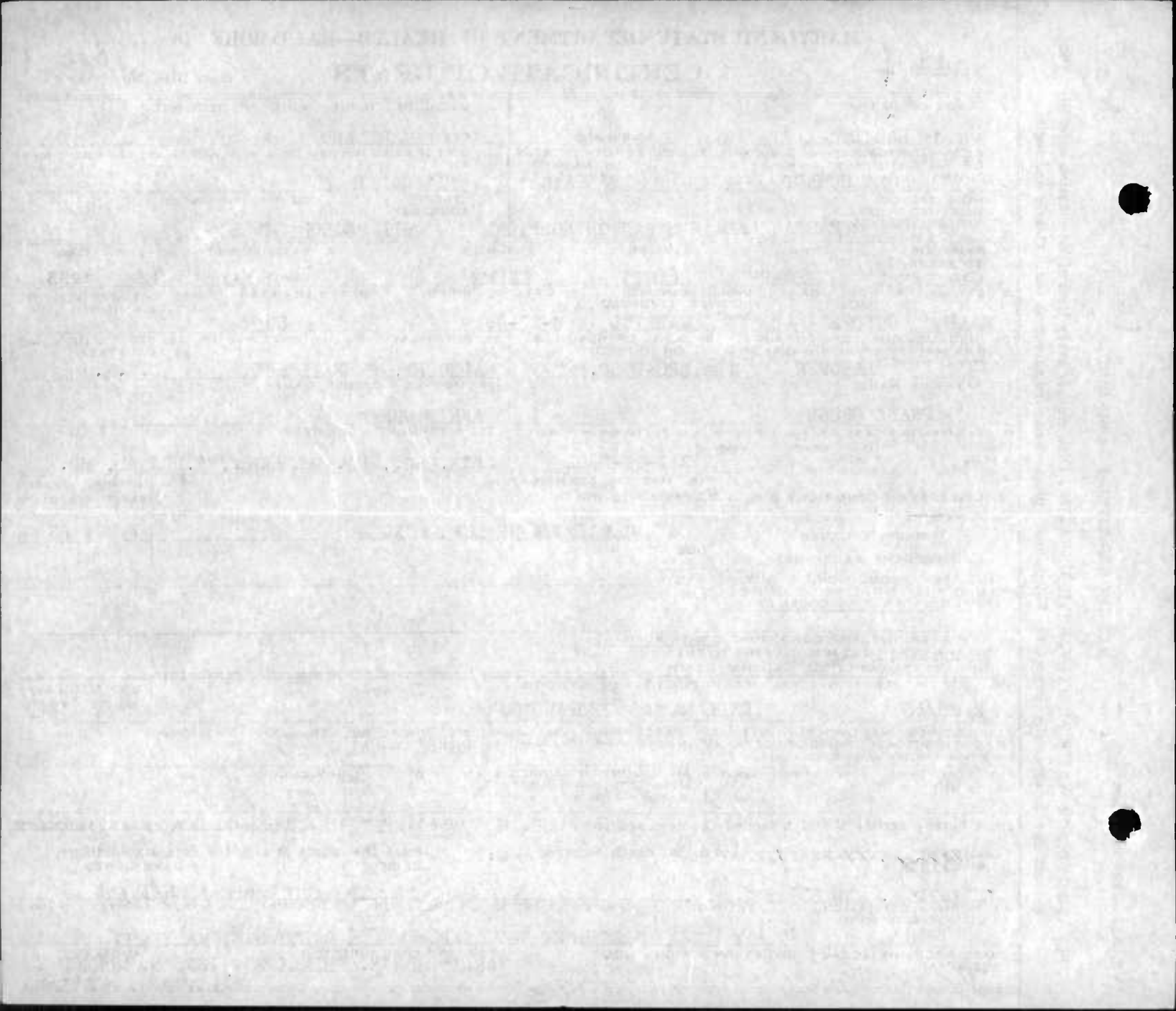
44-1

CERTIFICATE OF DEATH

Reg. Dist. No.

04378

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>FORT HOWARD</u>		<u>93 DAYS</u>		TOWN <u>BALTIMORE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>50 VETERANS ADMINISTRATION HOSPITAL</u>				<u>617 GEORGE STREET</u>			
3. NAME OF DECEASED: (Type or Print)		(First) (Middle) (Last)		4. DATE (Month) (Day) (Year)		OF DEATH:	
<u>STEWART</u>		<u>(NMI)</u> <u>GREEN</u>		<u>MAY</u> <u>12</u> <u>1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>MALE</u>	<u>COLORED</u>	<u>MARRIED</u>	<u>6-22-95</u>	<u>59 yrs.</u>	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>LABORER</u>		<u>RAILROAD CO.</u>		<u>ALTOONA, PENNSYLVANIA</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>FRANK GREEN</u>				<u>ANNIE GREEN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>1 YES</u>		<u>217-01-0892</u>		<u>CLIN.REC., VET.ADM.HOSP., FT.HOWARD, MD.</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
163X IMMEDIATE CAUSE (A) <u>CARCINOMA OF LEFT LUNG</u>						<u>7 MONTHS</u>	
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
<u>2/25/55</u>		<u>EXPLORATORY THORACOTOMY</u>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>FEB. 8, 1955</u> , to <u>MAY 12, 1955</u> , and that death occurred at <u>6:20A</u> M, from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>WILLIAM B. VANDEGRIFT, M.D.</u>		<u>M.D. VAH., FT. HOWARD, MD</u>		<u>5/13/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>5/16/1955</u>		<u>BALTIMORE NATIONAL</u>		<u>BALTIMORE, MARYLAND</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>May 16, 1955</u>		<u>A. W. Hedgrich</u>		<u>ARLINGTON S. PHILLIPS</u>		<u>1808 N. MONROE ST BALTIMORE, MARYLAND</u>	



CERTIFICATE OF DEATH

Reg. Dist. No. 38

4422

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore	MARYLAND	STATE Md.	COUNTY Balto.
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cockeysville	
X TOWN Lutherville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS College Manor Nursing Home		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) ARTHUR (Middle) L. (Last) GRISWOLD		4. DATE (Month) (Day) (Year) OF DEATH: May 4, 1955	
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed	8. DATE OF BIRTH: May 29, 1865
9. AGE last birthday: 89 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk(rtd)		10B. KIND OF BUSINESS OR INDUSTRY: State of Connecticut	11. BIRTHPLACE (State or foreign country): Connecticut
13. FATHER'S NAME: Orville B. Griswold		14. MOTHER'S MAIDEN NAME: Louisa Wight	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: Mrs. Albert Lathand-Cockeysville, Md.			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Cerebral Thrombosis, rt. middle emb.			48 hrs.
ANTECEDENT CAUSE (S): (B) Arteriosclerosis, cerebral			> 1 yr.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 5/4, 1955 , to 5/4, 1955 , that I last saw the deceased alive on 5/4, 1955 , and that death occurred at 5:45 P.M. from the causes and on the date stated above.			
SIGNATURE Harry F. Helmigfeldt		ADDRESS 1101 N. Calvert St., Balto. - 2, Md.	
DATE SIGNED 5/6/55		M. D. 1101 N. Calvert St., Balto. - 2, Md.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 5/9.55	NAME OF CEMETERY OR CREMATORY Wilimantic	LOCATION (City, town, or county) (State) Wilimantic, Conn.
DATE REC'D BY LOCAL REGISTRAR 5/6/55	REGISTRAR'S SIGNATURE a.w. Hedrick	24. FUNERAL DIRECTOR J.M. J. Sicker	ADDRESS 4 S. Calvert St., Balto. 17

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

INCOME TAX RETURN

1911

Name of Taxpayer		Residence	
Occupation		Source of Income	
Gross Income		Deductions	
Net Income		Tax	
Refund		Total	

THE TAXPAYER'S SIGNATURE AND THE SIGNATURE OF THE PREPARED BY MUST BE SUBMITTED WITH THIS RETURN.

RECEIVED BY THE DEPARTMENT OF REVENUE

05332
Reg. Dist.MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore	MARYLAND	STATE Maryland	COUNTY Baltimore
CITY (If outside corporate limits, write RURAL OR and give nearest town) UNKNOWN	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS UNKNOWN		STREET ADDRESS (If rural, give location) R.F.D. Box 767	
3. NAME OF DECEASED: (Type or Print) JACK		4. DATE OF DEATH May 2 19 55	
(First) (Middle) (Last) GUSYKIEWICZ		5. AGE last birthday: 70 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): U		10b. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): U		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: n k		14. MOTHER'S MAIDEN NAME: n k	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) o		16. SOCIAL SECURITY No.: W	
17. INFORMANT & ADDRESS: W		18. MEDICAL CERTIFICATION n	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
422.1 Immediate cause (a) Arteriosclerotic cardiovascular disease DUE TO			
Antecedent cause(s) (b) DUE TO Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: 2		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	
21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE William Wood		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 5/3/55 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. 5/3/55	
23. BURIAL, CREMATION, REMOVAL (Specify): Cremated		DATE THEREOF June 7, 1955 NAME OF CEMETERY OR CREMATORY Univ. of Maryland Med Sch. Balto., Maryland	
DATE REC'D BY LOCAL REG. June 9, 1955		REGISTRAR'S SIGNATURE H. W. Redrue	
24. FUNERAL DIRECTOR		ADDRESS 242 Anatomy Board Maryland per: M. Christie	

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 10 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4403 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 45

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto</u>	MARYLAND	STATE	COUNTY <u>Balto</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Essex</u>	LENGTH OF STAY (in this place) <u>34</u>	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Same</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>201 S. Taylor.</u>		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED:		DATE OF DEATH	
(Type or Print) <u>George Frederick Gutermuth</u>	(First) (Middle) (Last)	(Month) (Day) (Year)	<u>May 16 1955</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOW, DIVORCED (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Feb 29/1904</u>
9. AGE last birthday: <u>51</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life): <u>Deputy Sheriff, Balto., Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Baltimore, Md.</u>	
11. BIRTHPLACE (State or foreign country): <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Otto Gutermuth</u>		14. MOTHER'S MAIDEN NAME: <u>Eleanor Gulf.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY No.: <u>705-10-9203</u>	
17. INFORMANT & ADDRESS: <u>Donald Gutermuth (Son).</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary occlusion</u>			<u>5 min.</u>
DUE TO			
Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last</u>			
DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: <u>0</u>			19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) (Minute) <u>Dec 5-16-55 1:45 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>J. McQuinn M.D.</u>		DATE SIGNED <u>5/19/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>5/19/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Moreland U.P. Cem</u>		LOCATION (City, town, or county) (State) <u>Balto Md</u>	
DATE REC'D BY LOCAL REG. <u>5/21/55</u>		REGISTRAR'S SIGNATURE <u>Carl Hurley</u>	
24. FUNERAL DIRECTOR <u>Lassalle Funeral Home</u>		ADDRESS <u>7401 Belair Rd</u>	

BUREAU V. 3

MAY 25 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

44-4

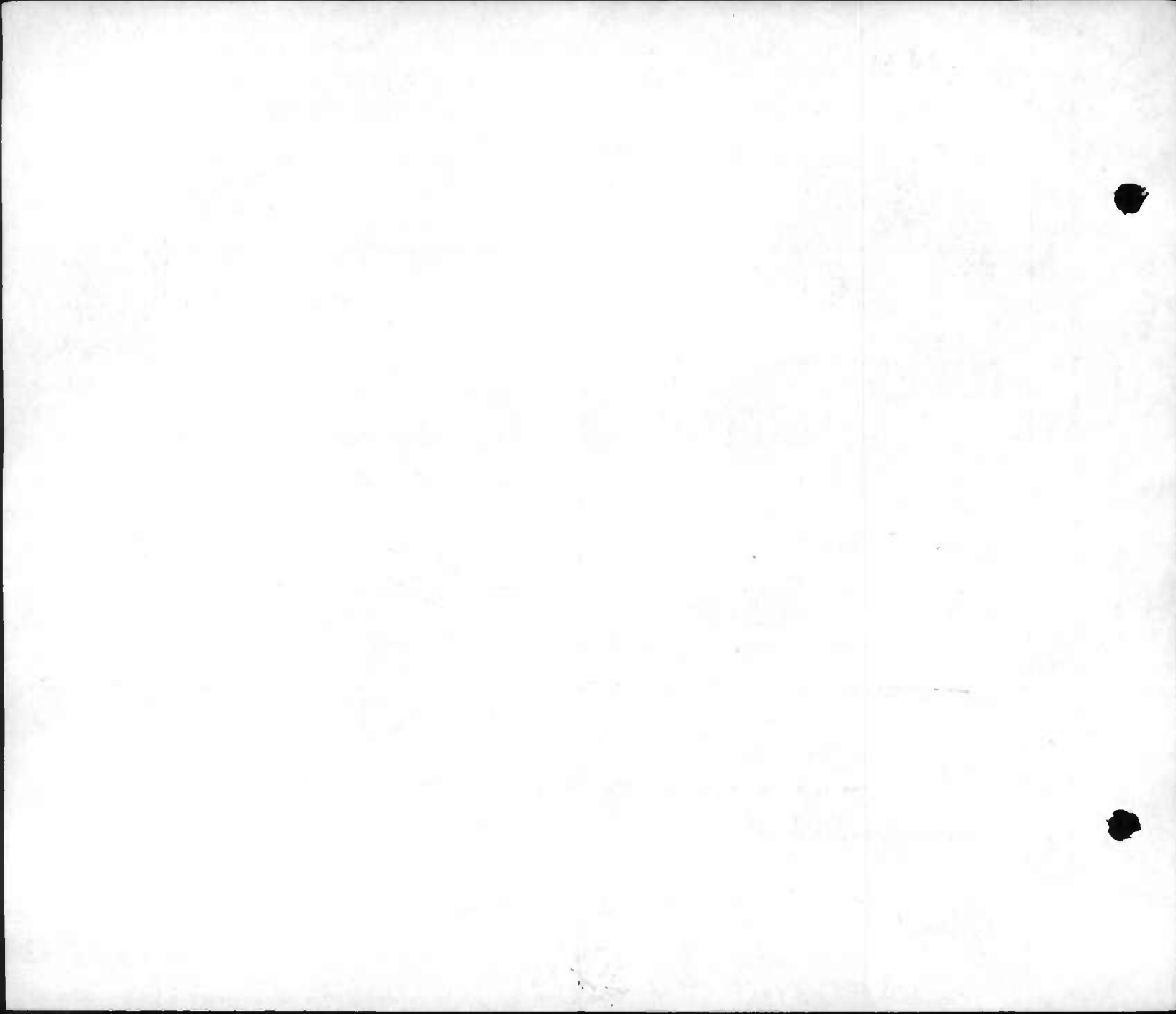
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04381

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTIMORE</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>BALTIMORE</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
<u>X</u> TOWN <u>BALTIMORE</u>	<u>11 YRS.</u>	<u>OVERLEA</u>	<u>X</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>00</u> <u>4201 PRAGUE AVE</u>		<u>4201 PRAGUE AVE</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>AGNES THERESA HAGAN</u>		DATE OF DEATH: <u>MAY 21 1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>FEMALE</u>	<u>WHITE</u>	<u>WIDOWED</u>	<u>MAY 14 1885</u>
9. AGE last birthday		IF UNDER 1 YEAR IF UNDER 24 HRS.	
<u>70</u> yrs.		Months	Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:	
<u>HOUSEWIFE</u>		<u>NONE</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>BOSTON MASS.</u>		<u>USA</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>PETER M. CURRAN</u>		<u>MARY A. REILEY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>NO</u>		<u>NO</u>	
17. INFORMANT & ADDRESS:			
<u>CHARLES W. FOWLER 4201 PRAGUE AVE</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
332X IMMEDIATE CAUSE (A) <u>CEREBRAL THROMBOSIS</u>		<u>2 MOS.</u>	
ANTECEDENT CAUSE (S) DUE TO (B) <u>CEREBRAL ARTERIOSCLEROSIS</u>		<u>10 YRS.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>0</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>3/24</u> , 19 <u>55</u> to <u>5/21</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/21</u> , 19 <u>55</u> , and that death occurred at <u>4 P.</u> M, from the causes and on the date stated above.			
SIGNATURE <u>J. W. Machin</u>		ADDRESS <u>M. D. 6331 Belair Rd</u> DATE SIGNED <u>5/23/1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>BURIAL</u>		<u>MAY 24 1955</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>HOLY REDEEMER</u>		<u>BELAIR RD</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>Doppel Brothers</u>		<u>7110 BELAIR RD</u>	



4405

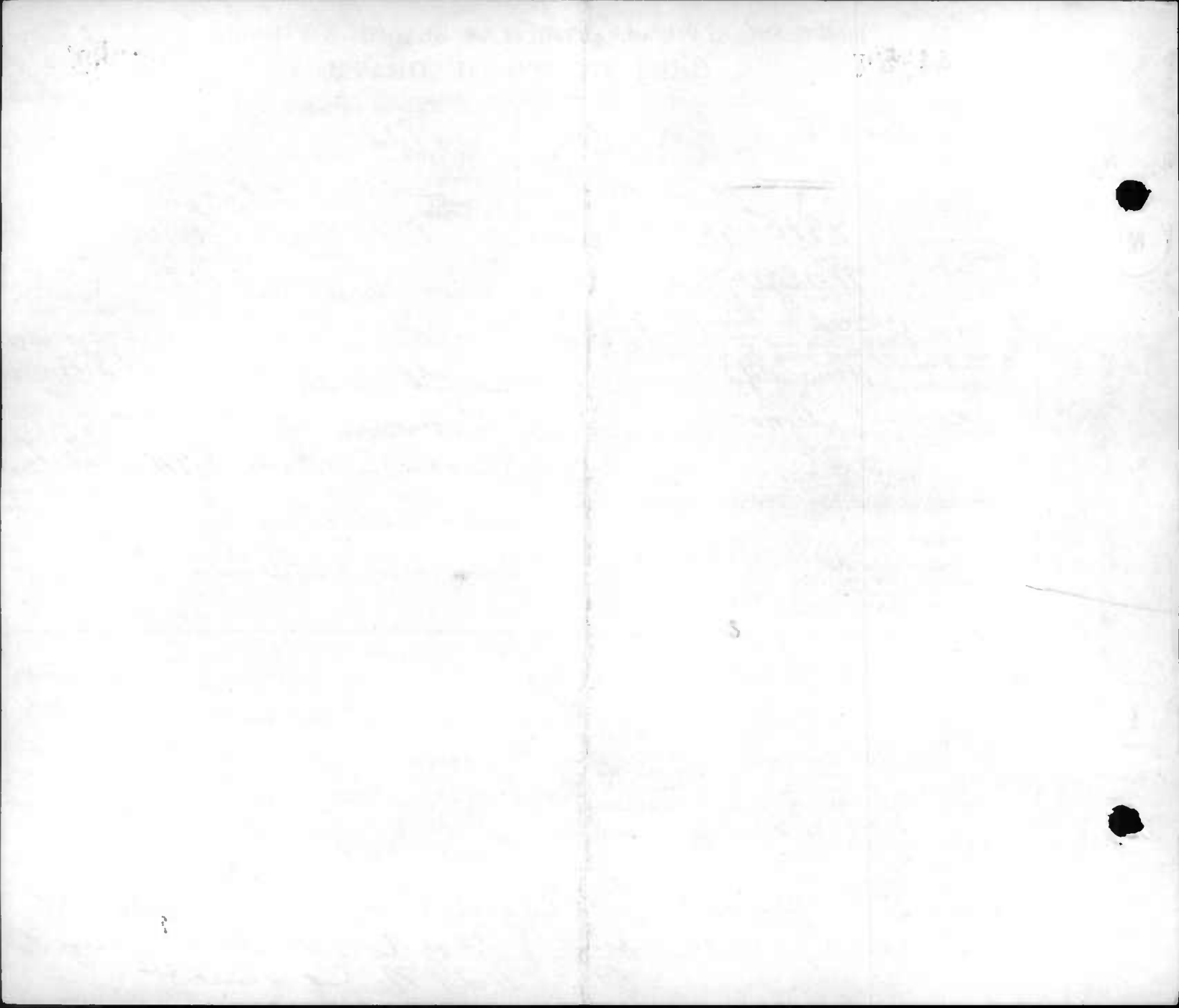
CERTIFICATE OF DEATH

Reg. Dist. No. 04382 38

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Balto</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X Parkville</u>	LENGTH OF STAY (in this place) <u>45 yrs.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8915 Heile Lane</u>		STREET ADDRESS (If rural give location) <u>8915 Heile Lane</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Margarette</u> (Middle) <u>Hale</u> (Last)		(Month) <u>5</u> (Day) <u>17</u> (Year) <u>1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>	8. DATE OF BIRTH: <u>April 17, 1873</u>
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday: <u>82</u> yrs. Months Days Hours Min.
11. FATHER'S NAME: <u>James Amos</u>		12. BIRTHPLACE (State or foreign country): <u>Bedford Co. Va.</u>	
13. MOTHER'S MAIDEN NAME: <u>Mormon</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
17. INFORMANT & ADDRESS: <u>Maudie Jenkins 8915 Heile Lane</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
<u>422.2</u> Immediate cause Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.		<u>Myocardial Insufficiency</u> <u>Senility & arteriosclerosis</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>March 1955</u> to <u>May 1955</u> , that I last saw the deceased alive on <u>May 1955</u> , and that death occurred at <u>2:17 PM</u> from the causes and on the date stated above.			
SIGNATURE <u>Frank G. Kaul</u>		DATE SIGNED <u>5/17/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
DATE THEREOF <u>May 20/55</u>		<u>Mt Calvary Cem</u>	
LOCATION (City, town, or county) (State)		<u>A. G. County Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-18-55</u>		REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>1129 N. Caroline St.</u>		<u>Mrs Rott & Elliott & Daugherty</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

44-6 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04383
CERTIFICATE OF DEATH Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>52 Catonsville</u>		LENGTH OF STAY (in this place) <u>1 yr. 10 mos. 6 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> <u>3401-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove State Hosp.</u>				STREET ADDRESS (If rural give location) <u>942 S. Paca St.</u>			
3. NAME OF DECEASED: (Type or Print) <u>Flora Harper</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>May 1, 1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED: <u>Widowed</u>	8. DATE OF BIRTH: <u>March 25, 1867</u>	9. AGE last birthday: <u>88</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Laundress</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA (Naturalized)</u>	
13. FATHER'S NAME: <u>No record</u>				14. MOTHER'S MAIDEN NAME: <u>No record</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>9</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>420.1</u>							
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Coronary thrombosis</u>						<u>5 min.</u>	
(B) <u>Terminal cardiorespiratory failure</u>						<u>Several hours</u>	
(C) <u>Bronchopneumonia - bilateral</u>						<u>10 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Generalized arteriosclerosis</u>						<u>Years</u>	
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 11, 1953</u> to <u>May 1, 1955</u> , that I last saw the deceased alive on <u>April 30, 1955</u> , and that death occurred at <u>5:35</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>John P. Riley M.D.</u>		ADDRESS <u>Spring Grove State Hospital Catonsville Md.</u>		DATE SIGNED <u>5/1/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>MAY 4, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Meadowridge</u>		LOCATION (City, town, or county) (State) <u>Elkridge, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-5-55</u>		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR <u>John O. Mitchell</u>		ADDRESS <u>1900 Euteria Pl.</u>	

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4477

CERTIFICATE OF DEATH

Reg. Dist. No. 04384 37

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <u>Cockeysville</u>		<u>14 yrs</u>		TOWN <u>Baltimore</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Masonic Home</u>				STREET ADDRESS (If rural give location) <u>1302 Morling Ave</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Ossieola Harper</u>				OF DEATH: <u>May 13 19 55</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>		8. DATE OF BIRTH: <u>Aug 18 - 1870</u>	
9. AGE last birthday: <u>84</u> - yrs.		<u>9</u> Months		<u>9</u> Days		IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own home</u>		11. BIRTHPLACE (State or foreign country): <u>Ellicott City Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>James W. Gosnell</u>				14. MOTHER'S MAIDEN NAME: <u>Annie Troop</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>9</u>		16. SOCIAL SECURITY No. <u>none</u>		17. INFORMANT & ADDRESS: <u>Laura M. Schroeder</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>422.1 Cardio Vascular Disease</u>							
ANTECEDENT CAUSE (B) <u>Arterio-sclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Ant 5 yrs</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/15, 1945</u> to <u>May 13, 1955</u> that I last saw the deceased alive on <u>May 13, 1955</u> , and that death occurred at <u>9:35 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Walter T. Lees</u>				ADDRESS <u>Cockeysville Md</u>		DATE SIGNED <u>May 13/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>5/16/55</u>		<u>London Pk</u>		<u>Baltimore Md</u>			
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
		<u>Laura M. Schroeder</u>		<u>Wm. Cook</u>		<u>St Paul & Preston St</u>	

RECEIVED

MAY 17 1955

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE		MARYLAND		STATE MARYLAND		COUNTY DORCHESTER	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Fort Howard		LENGTH OF STAY (in this place) 20 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CAMBRIDGE			
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL				STREET ADDRESS (If rural give location) 313 PINE STREET			
3. NAME OF DECEASED: (First) (Middle) (Last) CHARLES E. HARRIS				4. DATE (Month) (Day) (Year) OF DEATH: MAY 21 19 55			
5. SEX: MALE	6. COLOR OR RACE: COLORED	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE	8. DATE OF BIRTH: 9-14-08	9. AGE last birthday 46 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER		10B. KIND OF BUSINESS OR INDUSTRY: FOOD PACKING		11. BIRTHPLACE (State or foreign country): CAMBRIDGE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: EDWARD HARRIS				14. MOTHER'S MAIDEN NAME: ELLA PERRY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes WW-11				16. SOCIAL SECURITY NO. 312-16-7153		17. INFORMANT & ADDRESS: CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) TUBERCULOUS PERITONITIS						2 Months	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 2		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 1 , 19 55 , to May 21 , 19 55 , and that death occurred at 4:00 PM , from the causes and on the date stated above.							
SIGNATURE WILLIAM B. VANDEGRIFT, M.D.				ADDRESS VAH, Fort Howard, Md. DATE SIGNED 5/22/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 5/25/55		NAME OF CEMETERY OR CREMATORY Cambridge Bethel Cemetery		LOCATION (City, town, or county) (State) Cambridge, Maryland	
DATE REC'D BY LOCAL REGISTRAR 5/27/55		REGISTRAR'S SIGNATURE Dawson L. Farley		24. FUNERAL DIRECTOR Arlington S. Phillips Funeral Home		ADDRESS 1808 N. Monroe St. Baltimore, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 31 1955

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

44-9

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04386

CERTIFICATE OF DEATH

Reg. Dist. No. 44.....

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore	MARYLAND	STATE Maryland	COUNTY Baltimore
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN Sparrows Point	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Colgate	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 2549 Lodge Forrest Drive		STREET ADDRESS (If rural give location) 1 Riverside Avenue	
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) Margaret A. Harris		4. DATE (Month) (Day) (Year) OF DEATH: May 1, 1955	
5. SEX: female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed	8. DATE OF BIRTH: About Sept. 1877
9. AGE last birthday 77 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife		10B. KIND OF BUSINESS OR INDUSTRY: at home	11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME: unknown	
14. MOTHER'S MAIDEN NAME: unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: Maurice Pressman, 1102 Court Square Bldg.	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Cerebral Hemorrhage			24 hrs
ANTECEDENT CAUSE (B) Hypertensive C.V. Disease			5 yrs
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 0	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from May 1, 1955 , to May 1, 1955 that I last saw the deceased alive on May 1, 1955 , and that death occurred at 9:20 AM , from the causes and on the date stated above.			
SIGNATURE James P. Means		ADDRESS 520 D. St. Baltimore, Md. DATE SIGNED 5/2/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) burial	DATE THEREOF 5/4/55	NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	LOCATION (City, town, or county) (State) Baltimore, Maryland
DATE REC'D BY LOCAL REGISTRAR 5-2-55	REGISTRAR'S SIGNATURE A. W. [Signature]	24. FUNERAL DIRECTOR Win. Gork. Inc.	ADDRESS 1217 St. Paul St.

MU-5-8080

04387

MARYLAND STATE DEPARTMENT OF HEALTH

4332

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 41

1. PLACE OF DEATH- COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD.</u> COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK (22)</u>	
TOWN <u>DUNDALK</u>		TOWN <u>DUNDALK</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7703 MEATH ROAD</u>		STREET ADDRESS (If rural, give location) <u>7703 MEATH Rd.</u>	
3. NAME OF DECEASED (First) <u>ERNEST</u> (Middle) <u>ISAAC</u> (Last) <u>HARTER</u>		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>11</u> (Year) <u>53</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>27 FEB. 1871</u>
9. AGE last birthday <u>84</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>METAL PLATER</u>	
11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ISAAC HARTER</u>		14. MOTHER'S MAIDEN NAME <u>CORNELIUS (UNK)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MAYNARD E. HARTER - SON</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
422.1 Immediate cause (a) <u>Arterio Sclerotic Cardiac - Vascular Disease</u>		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c) <u>Sclerosis</u>		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>5/14/55</u>	19b. MAJOR FINDINGS OF OPERATION <u>None</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 16 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4410

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. 04388

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Washington, D.C.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rt. 40, 1/2 mile N. Ebenezer Rd.</u>				STREET ADDRESS (If rural, give location) <u>1956 Third St., N.E.</u>			
3. NAME OF DECEASED: (First) <u>CHARLOTTE</u>		(Middle) <u>A.</u>		(Last) <u>HAYES</u>		4. DATE OF DEATH (Month) <u>MAY</u> (Day) <u>6</u> (Year) <u>1955</u>	
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>		8. DATE OF BIRTH: <u>JAN 27, 1927</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>AT HOME</u>		9. AGE last birthday: <u>28</u> yrs.		11. BIRTHPLACE (State or foreign country): <u>WASHINGTON D.C.</u>	
13. FATHER'S NAME: <u>JULIAN JAMES COOKE</u>		14. MOTHER'S MAIDEN NAME: <u>ELSIE PATRICK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		(If Yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY No.: <u>YES</u>		17. INFORMANT & ADDRESS: <u>MR. JOHN T HAYES 1956-3rd St. N.E. Wash. D.C.</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Multiple extreme injuries of body</u>							
DUE TO							
Antecedent cause(s) (b) <u>giving rise to the above cause</u>							
DUE TO							
stating underlying cause last (c) <u>Acute alcoholism</u>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>0</u>		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) <u>INJURY street</u>		21c. (City or town) <u>Rt. 40</u> (County) <u>Balto.</u> (State) <u>03 Md.</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>5/6/55</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Driver of auto struck culvert</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>B. Fisher</u>		M. D. ASSISTANT MEDICAL EXAM. <u>May 6, 1955</u>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF <u>May 10, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>FORESTVILLE EPIS. CEMETERY</u>		LOCATION (City, town, or county) (State) <u>FORESTVILLE, MD.</u>	
DATE REC'D BY LOCAL REG. <u>MAY 8 1955</u>		REGISTRAR'S SIGNATURE <u>Huntington Williams</u>		24. FUNERAL DIRECTOR <u>W. L. CHAMBERS</u>		ADDRESS <u>WASH. D.C.</u>	

4410
RECEIVED
JAN 11 1941

TO THE DIRECTOR
BUREAU OF REVENUE
WASHINGTON, D. C.

FROM THE
SAC, NEW YORK

SUBJECT: [Illegible]

[The remainder of the document contains several paragraphs of extremely faint, illegible text, likely a memorandum or letter. The text is mirrored across the page, suggesting a bleed-through from the reverse side.]

4411

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE		MARYLAND		STATE MARYLAND		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN FORT HOWARD		47 DAYS		OR TOWN BALTIMORE			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
50 VETERANS ADMINISTRATION HOSPITAL				1119 LAURENS STREET			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
JOHN JOSEPH HEFNER				DEATH: MAY 3 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
MALE	WHITE	MARRIED	5-29-98	56 yrs	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
PRODUCE WORK		SELF EMPLOYED		BALTIMORE, MARYLAND		U. S. A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
JOHN HEFNER				ANNIE SMITH			
15. WAS DECEASED EVER IN U.S. ARMED FORCE? (Yes, no or unk)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
YES (If Yes, give war or dates of service) WW I		UNKNOWN		CLIN.REC., VET.ADM.HOSP., FT.HOWARD, MD.			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
199.9 IMMEDIATE CAUSE						Approximate	
(A) METASTATIC CARCINOMA, PRIMARY SITE NOT KNOWN						ly 4 Mos.	
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						Unknown	
GENERALIZED ARTERIOSCLEROSIS							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4-15-55		EXCISION OF TISSUE FROM LESION OF RIGHT SCAPULA					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21E. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
VA M.							
22. I hereby certify that I attended the deceased from MAR. 17, 1955, to MAY 3, 1955 , and that death occurred at 1:30AM , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
Francis G. Dickey, M.D.		M. D. VAH, FORT HOWARD, MARYLAND		5-3-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		5/7/55		NEW CATHEDRAL CEMETERY		BALTIMORE, MARYLAND	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
5-5-55		AW Helms		Wm. Tickner & Sons, Inc.		North & Penna. Ave. Baltimore, Maryland	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

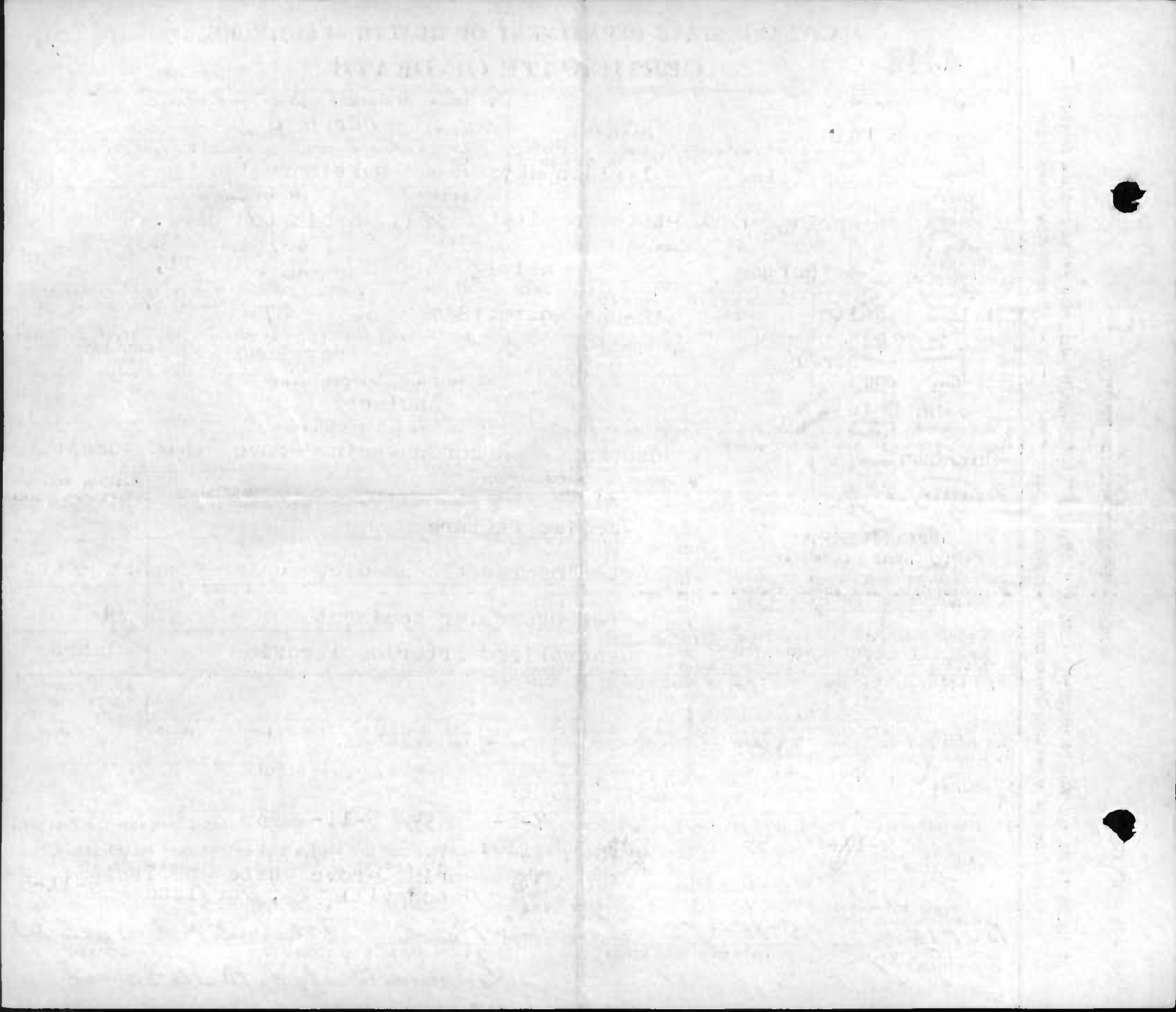
04390

4412

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
52 TOWN <u>Catonsville</u>		1 yr 10 mo 5 days		TOWN <u>Baltimore</u> 3 yr 1 - 4			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>				STREET ADDRESS (If rural give location) <u>2611 Washington Blvd.</u> ✓			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Herman Helwig</u>				<u>May 11, 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>9-10-1867</u>	<u>87 yrs</u>	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>John Helwig</u>				14. MOTHER'S MAIDEN NAME: <u>Louise ?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) [If Yes, give war or dates of service]: <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hospital</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) <u>Cardiac failure</u>						<u>8 days</u>	
ANTECEDENT CAUSE (S): (B) <u>Arteriosclerotic cardiovascular disease</u>						<u>Years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Cerebrovascular accident</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Generalized arteriosclerosis</u>						<u>Years</u>	
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7:46</u> , 19 <u>53</u> to <u>5-11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-11</u> , 19 <u>55</u> , and that death occurred at <u>10:15</u> M. from the causes and on the date stated above.							
SIGNATURE <u>S. Wachler</u>		DATE SIGNED <u>5-11-55</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>5-15-55</u>		NAME OF CEMETERY OR CREMATORY <u>Lowden Park</u>		LOCATION (City, town, or county) (State) <u>Frederick Rd Baltimore</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 12, 1955</u>		REGISTRAR'S SIGNATURE <u>G. W. Hedrich</u>		24. FUNERAL DIRECTOR <u>Edward Johnson</u>		ADDRESS <u>Baltimore 30 rd</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04391

4413

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH: COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>BALTIMORE CITY</u> COUNTY <u>03-52-1</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CATONSVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>CATON RIDGE NURSING HOME</u>		STREET ADDRESS (If rural, give location) <u>HARLEM LANE CATONSVILLE</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>ANNA</u>	(Middle) <u>VIRGINIA</u>	(Last) <u>HESS</u>
4. DATE OF DEATH	(Month) <u>5</u>	(Day) <u>27</u>	(Year) <u>1955</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WH.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W.</u>	8. DATE OF BIRTH <u>2/15/75</u>
9. AGE last birthday <u>80</u> yrs.		If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Portford Co. Ind.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JACOB H. Hess</u>		14. MOTHER'S MAIDEN NAME <u>Wary West</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY No. <u>?</u>	
17. INFORMANT <u>MILTON HESS (SON)</u>		18. MEDICAL CERTIFICATION <u>2208 Taylor Ave Balto.</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
150X Immediate cause (a) <u>Respiratory failure</u>		<u>3 days</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Cancer & Emphysema</u>		<u>unknown</u>	
(c) <u>Dehydration & Incontinence</u>		<u>1 month</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Emphysema about 2 miles up at John Hopkins Lung Fund</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>NO</u>	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July 14, 1955</u> , to <u>July 26, 1955</u> , that I last saw the deceased alive on <u>July 26, 1955</u> , and that death occurred at <u>4:40</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Chf. Raliff J. M.D.</u>		ADDRESS <u>4605 Edmondson Ave Balto 29</u>	
DATE SIGNED <u>5/27/55</u>			
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>May 30 55</u>	NAME OF CEMETERY OR CREMATORY <u>Gordwell</u>	LOCATION (City, town, or county) (State) <u>Ridgely Md</u>
DATE REC'D BY LOCAL REG. <u>5/27/55</u>	REGISTRAR'S SIGNATURE <u>T.E. Harry</u>	24. FUNERAL DIRECTOR <u>Warton R. Raliff</u>	
		ADDRESS <u>John Raliff</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 31 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04392

4414

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) 52 Catonsville		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 34014			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 Catonsville Nursing Home				STREET ADDRESS (If rural give location) unknown ✓			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DAISY C. HOHMAN				May 9, 1955			
5. SEX: female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed	8. DATE OF BIRTH: Nov. 24, 1869	9. AGE last birthday: 85 yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS.: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife		10B. KIND OF BUSINESS OR INDUSTRY: at home		11. BIRTHPLACE (State or foreign country): Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME: James T. Barker				14. MOTHER'S MAIDEN NAME: unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): 4 (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: 4415 Colesville Road Harry A. L. Barker, Riverdale, Maryland			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) 422.1 Broncho pneumonia						36 hrs	
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) ASCVD - grade III						unknown	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1-12 , 19 55 , to 5-8 , 19 55 , that I last saw the deceased alive on 5-9 , 19 55 , and that death occurred at 11:30 P M. from the causes and on the date stated above.							
SIGNATURE Stephen Lee Haggness		M. D.		ADDRESS Caronsville		DATE SIGNED 5-9-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		DATE THEREOF 5/12/55		NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		LOCATION (City, town, or county) (State) Baltimore, Maryland	
DATE REC'D BY LOCAL REGISTRAR 5-10-55		REGISTRAR'S SIGNATURE Wm. Bork, Inc.		24. FUNERAL DIRECTOR ADDRESS 1217 St. Paul Street			

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4415

04393

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTO. CO.</u> MARYLAND				STATE <u>MD</u> COUNTY <u>BALTO.</u>			
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>CATONSVILLE</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>CATONSVILLE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5 S. ROLLING RD.</u>				STREET ADDRESS (If rural give location) <u>5 S. ROLLING RD.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>CATHERINE R. HUTSON</u>				OF DEATH: <u>5/16/55</u>			
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>		8. DATE OF BIRTH: <u>APR. 27 1883</u>	
				9. AGE last birthday: <u>72</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Domestic</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>MD</u>	
13. FATHER'S NAME: <u>CHAS. J. BLUMENAUER</u>				14. MOTHER'S MAIDEN NAME: <u>MARK T. HUBERT</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mrs. Theresa Lubner</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>						<u>Sudden</u>	
ANTECEDENT CAUSE (B) <u>Coronary thrombosis & CAD</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Vascular Disease</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/20</u> , 19 <u>38</u> , to <u>5/16</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9/12</u> , 19 <u>55</u> , and that death occurred at <u>10:25 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Eliot W. Johnson</u>				ADDRESS <u>M. D. 3432 Eastern Ave. Baltimore Md</u>		DATE SIGNED <u>5/17/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>5/20/55</u>		<u>LOUDON PARK</u>		<u>BALTO. MD</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/18/55</u>		REGISTRAR'S SIGNATURE <u>T. E. Harvey</u>		24. FUNERAL DIRECTOR <u>Donald Pratt & Son</u>		ADDRESS	

RECEIVED

MAY

BUREAU V. S.

4416

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

R4384

No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits write RURAL and give nearest town)	OR
<u>52</u> TOWN <u>Catonsville</u>	<u>14yr 2mo 9days</u>	TOWN <u>Baltimore</u>	<u>3001-4</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		STREET ADDRESS (If rural, give location) <u>2603 Shirley Avenue</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<u>Eva Isaacson</u>		<u>May 20, 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>Unknown</u>
9. AGE last birthday: <u>70?</u> yrs.		IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country): <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
13. FATHER'S NAME: <u>Michael Berger</u>		14. MOTHER'S MAIDEN NAME: <u>Annie Himmelfarb</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>Unknown</u>	
<u>No</u>		17. INFORMANT & ADDRESS: <u>Records of Spring Grove State Hospital</u>	

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
<u>4201</u> Immediate cause (a) <u>Coronary thrombosis</u> DUE TO Antecedent cause(s) (b) <u>Arteriosclerotic cardiovascular disease</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Mental Illness</u>			
19a. DATE OF OPERATION: <u>0</u>		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>Dr. M. Kipper</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>5-20-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>5-22-55</u>	NAME OF CEMETERY OR CREMATORY: <u>Rosedale</u>	LOCATION (City, town, or county) (State): <u>Balto Md.</u>
DATE REC'D BY LOCAL REG. <u>5/21/55</u>	REGISTRAR'S SIGNATURE: <u>T.E. Barry</u>	24. FUNERAL DIRECTOR: <u>Jack Lewis</u> ADDRESS: <u>3100 Eutan Rd</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

4118

MARYLAND STATE DEPARTMENT OF HEALTH - DISTRICT OF COLUMBIA
ADMINISTRATIVE SERVICES DIVISION - CIVIL SERVICE

BUREAU V. S.

MAY 23 1955

RECEIVED

FOR THE DIRECTOR OF HEALTH

4417

CERTIFICATE OF DEATH

Reg. Dist. No. 04395

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Baltimore</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Balti</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Garrison</i>	LENGTH OF STAY (In this place) <i>6 yrs</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Garrison</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	

3. NAME OF DECEASED: (Type or Print) <i>Howard E Jackson</i>		4. DATE OF DEATH: (Month) <i>May</i> (Day) <i>3</i> (Year) <i>1955</i>	
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Single</i>	8. DATE OF BIRTH: <i>Nov 20-1869</i>
9. AGE last birthday: <i>85</i> yrs.		10. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired <i>Retired Teacher High School</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>None</i>	
11. BIRTHPLACE (State or foreign country): <i>MD.</i>		12. CITIZEN OF WHAT COUNTRY: <i>USA</i>	
13. FATHER'S NAME: <i>Elisha Jackson</i>		14. MOTHER'S MAIDEN NAME: <i>Elizabeth Price</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY No.: <i>No</i>	
17. INFORMANT & ADDRESS: <i>Mrs. Lucie Pittenger Garrison Md.</i>			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
422.1 Immediate cause (a) <i>Decompensation of Heart</i>		2 days
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <i>Chs. Valr. Heart Disease</i>		
260X (c) <i>Cardio Vascular Disease</i>		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Diabetes</i>		
19a. DATE OF OPERATION: <i>5/2/55</i>		19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>		
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *1955*, to *5/2/55*, that I last saw the deceased alive on *5/2/55*, and that death occurred at *7 PM* from the causes and on the date stated above.

SIGNATURE *Wm E Martin* (Degree or title) ADDRESS *Wm E Martin* DATE SIGNED *5/3/55*

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town or county) (State)
<i>Interment</i>	<i>May 6-1955</i>	<i>Hampstead</i>	<i>Carroll Co Md.</i>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<i>5/4/55</i>	<i>Mary B. Elise</i>	<i>Edw C. Sifton</i>	<i>Hampstead Md.</i>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 9 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04396

CERTIFICATE OF DEATH

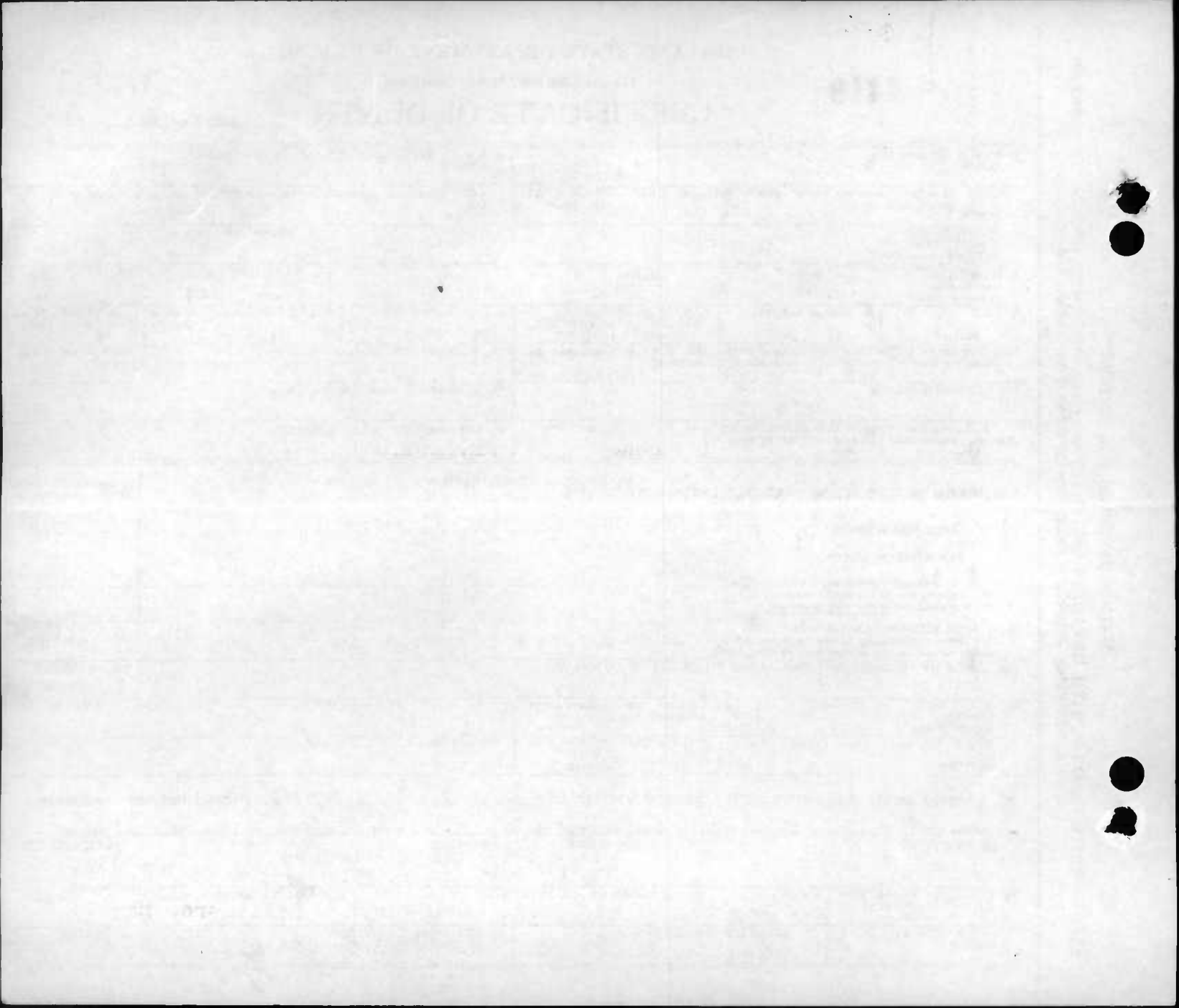
Reg. Dist. No. 43

1. PLACE OF DEATH- COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland		COUNTY Balto	
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN Rossville		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rossville		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 153 Lenning Lane				STREET ADDRESS (If rural, give location) 153 Lenning Lane			
3. NAME OF DECEASED (Type or Print)		(First) GEORGE LEE		(Middle) JEFFERSON,		(Last) SR.	
5. SEX Male		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widower		8. DATE OF BIRTH March 17, 1871	
						9. AGE last birthday 84 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter		10b. KIND OF BUSINESS OR INDUSTRY contractor		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Jefferson				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No. none		17. INFORMANT AND ADDRESS Mr. Howard L. Jefferson		same	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.0 Immediate cause (a) Arteriosclerotic Heart Disease				2 years			
Antecedent cause(s)							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				Acute Myelogenous Leukemia			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from March, 1955, to May, 1955, that I last saw the deceased alive on May 12, 1955, and that death occurred at 4:35 a.m., from the causes and on the date stated above.							
SIGNATURE James R. Wilson, M.D.				ADDRESS 8019 Philadelphia Road Baltimore 6, Md.		DATE SIGNED May 13, 1955	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE May 16, 1955		NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		LOCATION (City, town, or county) (State) Baltimore, Maryland	
DATE REC'D BY LOCAL REG. 5-16-55		REGISTRAR'S SIGNATURE G. W. Hedrick		24. FUNERAL DIRECTOR H. SANDER & SONS, INC.		ADDRESS Baltimore, Maryland	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



4333

MARYLAND STATE DEPARTMENT OF HEALTH

04397

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Item 7. Film G182 6-6-55 et

Reg. Dist. No. 41

1. PLACE OF DEATH - COUNTY BALTO MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE MD. BALTO. COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) DUNDALK (22)		CITY (If outside corporate limits, write RURAL and give nearest town) DUNDALK (22)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 2510 YORKWAY		STREET ADDRESS (If rural, give location) 2510 YORKWAY	
3. NAME OF DECEASED (First) OLUF (Middle) (N.M.I.) (Last) JENSEN	4. DATE OF DEATH (Month) 5-28 (Day) 19 (Year) 55		
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) GARAGE	8. DATE OF BIRTH 5-4-1892 9. AGE last birthday 63 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC		10b. KIND OF BUSINESS OR INDUSTRY GARAGE	
11. BIRTHPLACE (State or foreign country) DENMARK		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PAUL JENSEN		14. MOTHER'S MAIDEN NAME SINE (?)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WWI		16. SOCIAL SECURITY No. 212-30-2740	
17. INFORMANT MIMI JENSEN - WIDOW			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) 420.1 Coronary Occlusion		
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE **John D. Davis M.D.** (Degree or title) ADDRESS **Sup. H. Ex. - Dundalk, Md.** DATE SIGNED **5/28/55**

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL	DATE THEREOF 5-30-55	NAME OF CEMETERY OR CREMATORY PAK LAWN	LOCATION (City, town, or county) (State) BALTO. Co., Md.
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE May 28-1955 William M. Kelly		24. FUNERAL DIRECTOR Walter Burke Bradley, Dundalk, Md. ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 1 1965

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4419

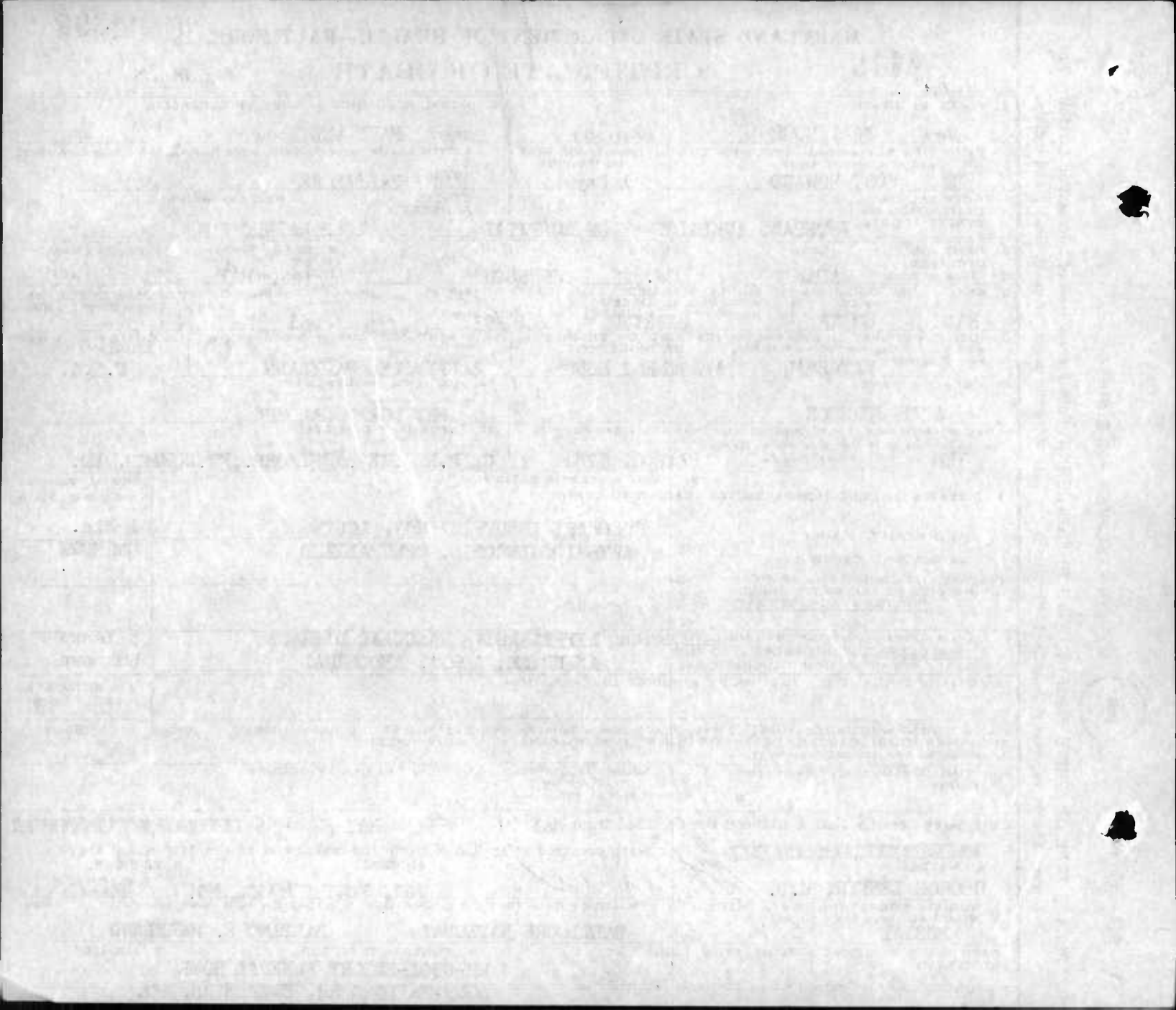
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04398

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE		MARYLAND		STATE MARYLAND		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN FORT HOWARD		1 Day		TOWN BALTIMORE (4) X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
50 VETERANS ADMINISTRATION HOSPITAL				1642 NATURO ROAD			
3. NAME OF DECEASED: (Type or Print)		(First) ADAM		(Middle) H.		(Last) JOHNSON	
4. DATE (Month) (Day) (Year) OF DEATH:		MAY 22 1955					
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
MALE	WHITE	MARRIED	9/13/93	61 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
WATCHMAN		APARTMENT HOUSE		BALTIMORE, MARYLAND		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
ADAM JOHNSON				MATILDA DONALDSON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
YES <input checked="" type="checkbox"/> WW-I				212 07 5288		CLIN.REC.VET.ADM.HOSP., FT.HOWARD, MD.	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) CORONARY INSUFFICIENCY, ACUTE							
ANTECEDENT CAUSE (B) DUE TO ARTERIOSCLEROSIS, GENERALIZED							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. HYPERTENSIVE VASCULAR DISEASE ANEURISM, AORTA, ABDOMINAL							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
0							
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
VA M.							
22. I hereby certify that I attended the deceased from MAY 21 , 19 55 , to MAY 22 , 19 55 , and that death occurred at 9:30A M. from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
GEORGE LERNER, M.D.		VAH, FORT HOWARD, MD.		5/22/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
BURIAL		5/25/55		BALTIMORE NATIONAL		BALTIMORE, MARYLAND	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
5/28/55		G. H. Hedrich		WM-COOK-BLIGHT FUNERAL HOME		6009 HARFORD Rd. BALTIMORE, MD.	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

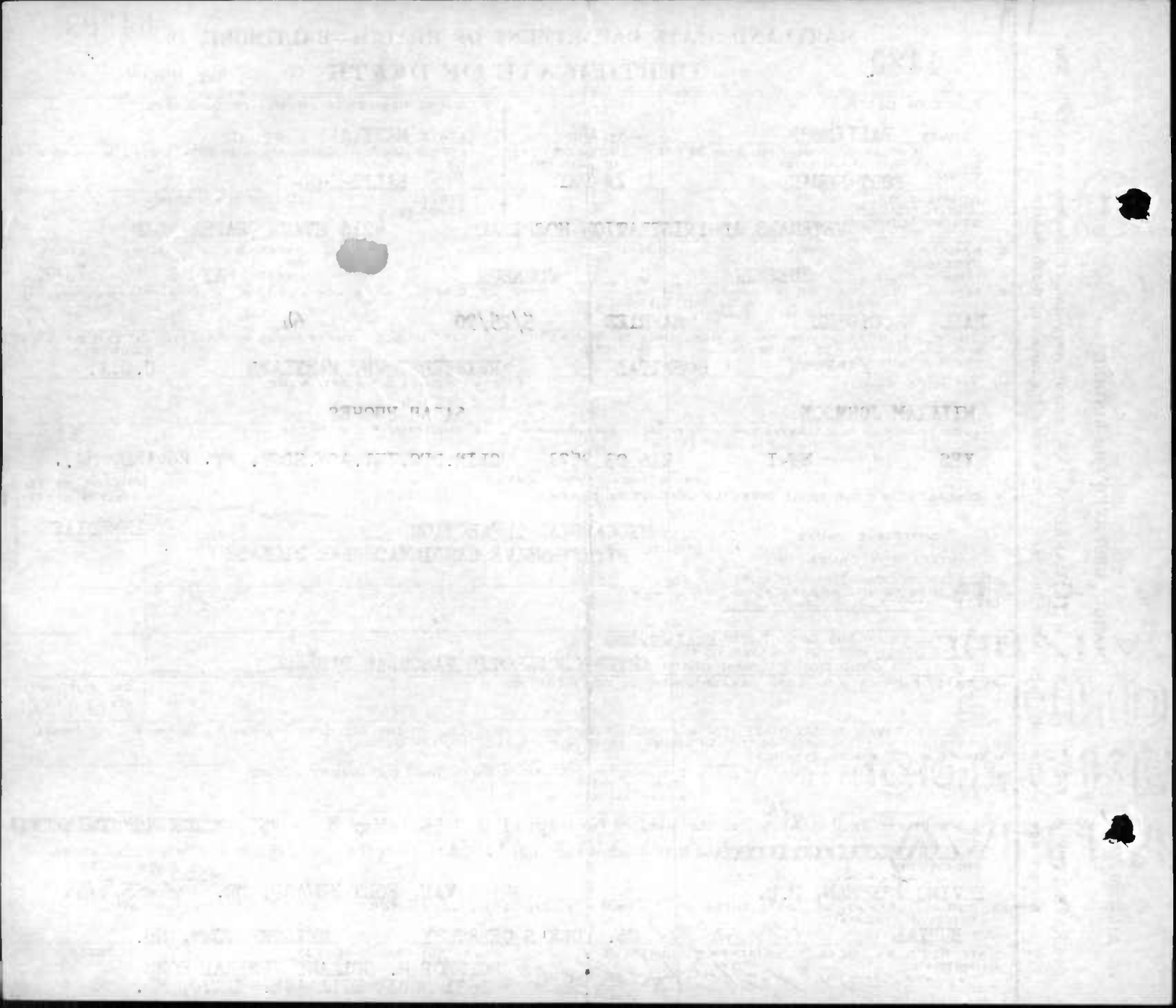
04399

4420

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY BALTIMORE	MARYLAND	STATE MARYLAND	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN FORT HOWARD	29 DAYS	TOWN BALTIMORE	3Y01-4
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
VETERANS ADMINISTRATION HOSPITAL		4216 EVANS CHAPEL ROAD	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
RUSSELL C JOHNSON		DEATH: MAY 8 1955	
5. SEX: MALE	6. COLOR OR RACE: COLORED	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED	8. DATE OF BIRTH: 5/25/90
9. AGE last birthday: 64 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FIREMAN		10B. KIND OF BUSINESS OR INDUSTRY: HOSPITAL	
11. BIRTHPLACE (State or foreign country): REISTERSTOWN, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: WILLIAM JOHNSON		14. MOTHER'S MAIDEN NAME: SARAH HUGHES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): YES (If Yes, give war or dates of service): WW-I		16. SOCIAL SECURITY NO.: 216 03 9571	
17. INFORMANT & ADDRESS: CLIN. REC. VET. ADM. HOSP., FT. HOWARD, Md.			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		IMMEDIATE	
IMMEDIATE CAUSE: 420.1			
ANTECEDENT CAUSE (S):			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.			
(A) MYOCARDIAL INFARCTION			
DUE TO HYPERTENSIVE CARDIOVASCULAR DISEASE			
(B)			
DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. ARTERIOSCLEROTIC VASCULAR DISEASE			
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: VA M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from April 9, 1955 , to May 8, 1955 , the DEATH occurred at 5:55A M. from the causes and on the date stated above.			
SIGNATURE: Irving Freeman		ADDRESS: VAH, FORT HOWARD, MD.	
DATE SIGNED: 5/8/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL		DATE THEREOF: MAY 12, 1955	
NAME OF CEMETERY OR CREMATORY: ST. LUKE'S CEMETERY		LOCATION (City, town, or county) (State): REISTERSTOWN, Md.	
DATE REC'D BY LOCAL REGISTRAR: 5-11-55		REGISTRAR'S SIGNATURE: Hedrick	
24. FUNERAL DIRECTOR: GEORGE H. HOLLAND FUNERAL HOME		ADDRESS: 1631 DRUID HILL AVE. BALTO, MD.	



4421

CERTIFICATE OF DEATH

Reg. Dist. No. 37.....

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Baltimore</i>	MARYLAND <i>MD</i>	STATE <i>MD</i>	COUNTY <i>Balt</i>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <i>Cockeysville</i>	<i>17 Months</i>	TOWN <i>Baltimore</i>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>90 Harmon Home</i>		STREET ADDRESS (If rural give location) <i>506 B. St. Sparrow Point</i>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<i>Gertrude Leonard Jones</i>		DATE OF DEATH: <i>May 16 1955</i>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
<i>Female</i>	<i>White</i>	<i>Widow</i>	<i>Nov. 10-1877 - 77 yrs. 6 Months</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housework</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Own home</i>	11. BIRTHPLACE (State or foreign country): <i>Chicago</i>
13. FATHER'S NAME: <i>Thomas Leonard</i>		14. MOTHER'S MAIDEN NAME: <i>Mary</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT & ADDRESS: <i>Laura M. Schneider</i>
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Cerebral Vascular accident</i>			<i>3 days</i>
ANTECEDENT CAUSE (B) <i>Generalized & Cerebral arteriosclerosis</i>			<i>Several years</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Dec. 1953</i> to <i>May 16, 1955</i> that I last saw the deceased alive on <i>May 16, 1955</i> , and that death occurred at <i>10:00 AM</i> , from the causes and on the date stated above.			
SIGNATURE <i>Walter T. Lees</i>		ADDRESS <i>Cockeysville</i>	DATE SIGNED <i>17 May 1955</i>
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<i>May 18-55</i>		<i>Druid Ridge Cemetery</i>	<i>Baltimore MD</i>
DATE REC'D BY LOCAL REGISTRAR <i>May 19 55</i>		REGISTRAR'S SIGNATURE <i>Laura M. Schneider</i>	24. FUNERAL DIRECTOR <i>Wm. Cook</i> ADDRESS <i>St Paul & Preson St</i>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 15 1961

BUREAU V. S.

04401

MARYLAND

STATE DEPARTMENT OF HEALTH

4422

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Owings Mills		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Owings Mills	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Park Heights Ave.		STREET ADDRESS (If rural, give location) Park Heights Ave.	
3. NAME OF DECEASED (Type or Print) Samuel G Kelley		4. DATE OF DEATH May 14, 1955	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH April 13, 1908
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employed at Hunter Wilson Distillery		9. AGE last birthday 47 yrs.	11. BIRTHPLACE (State or foreign country) Virginia
13. FATHER'S NAME Thomas L. Kelley		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) No		14. MOTHER'S MAIDEN NAME Martha Vest	
16. SOCIAL SECURITY No. 215-22-4684		17. INFORMANT AND ADDRESS Mrs. Rennis G. Kelley, Owings Mills, Md.	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.2 Immediate cause (a) Angina Pectoris			2½ mos.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) (b) Lumbar intervertebral disc			10½ mos.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION 12-25-55		19b. MAJOR FINDINGS OF OPERATION Lumbar disc	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE none		PLACE (Home, farm, factory, street, OF office bldg., etc.) none	
TIME (Month) (Day) (Year) (Hour) OF INJURY none		INJURY OCCURRED While at Not While Work <input type="checkbox"/> none <input type="checkbox"/>	
		HOW DID INJURY OCCUR? none	
22. I hereby certify that I attended the deceased from 11-3 , 19 40 , to 5-14 , 19 55 , that I last saw the deceased alive on 5-14-55 , 19 55 , and that death occurred at 4:30A. m., from the causes and on the date stated above.			
SIGNATURE D. S. Caples		ADDRESS 6 Hanover Rd., Reisterstown, Md.	
23. BURIAL, CREMATION REMOVAL, (Specify) Burial		DATE May 17, 1955	
NAME OF CEMETERY OR CREMATORY Dover Cemetery		LOCATION (City, town, or county) (State) Baltimore County	
DATE REC'D BY LOCAL REC. 5-16-55		24. FUNERAL DIRECTOR J.F. Eline & Sons, Reisterstown, Md.	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

MAY 23 1965

RECEIVED

4423

CERTIFICATE OF DEATH

Reg. Dist. No. 3

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Balto.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Lochearn</u>	
<input checked="" type="checkbox"/> TOWN <u>Lochearn</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3617 Patterson Ave.</u>		STREET ADDRESS (If rural give location) <u>3617 Patterson Ave.</u>	
3. NAME OF DECEASED: (First) <u>PETER</u> (Middle) <u>JOSEPH</u> (Last) <u>KELLY, JR.</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>May</u> <u>31</u> , 19 <u>55</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>	8. DATE OF BIRTH: <u>Sept. 17, 1949</u>
9. AGE last birthday <u>5</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. BIRTHPLACE (State or foreign country): <u>Md.</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>none</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
13. FATHER'S NAME: <u>Peter Joseph Kelly, Sr.</u>		14. MOTHER'S MAIDEN NAME: <u>M. Elizabeth Slenaker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT & ADDRESS: <u>Mr. P. J. Kelly, Sr. - 3617 Patterson Ave.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		<u>1 month</u>	
587.2 IMMEDIATE CAUSE (A) <u>Heart Failure</u>			
ANTECEDENT CAUSE (S): (B) <u>Cystic Fibrosis of PANCREAS</u>		<u>since birth</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>BRONCHIECTASIS + PNEUMONIA</u>		<u>2 yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Sept 18, 1949 to May 31, 1955</u> , that I last saw the deceased alive on <u>May 31, 1955</u> , and that death occurred at <u>7 P. M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Wille W. D.</u> M.D.		DATE SIGNED <u>June 1 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>6/3/55</u>	NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>	LOCATION (City, town, or county) (State) <u>Balto., Md.</u>
DATE REC'D BY LOCAL REGISTRAR <u>6-2-55</u>	REGISTRAR'S SIGNATURE <u>RW Hedrick</u>	24. FUNERAL DIRECTOR <u>Wm. J. ...</u>	ADDRESS <u>...</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4424

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04403

CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Middleboro</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Middleboro</u>		TOWN <u>Middleboro</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <u>209 Helena Rd.</u>			
3. NAME OF DECEASED: (Type or Print) <u>OTTO J. KLEMPSTEIN</u>				4. DATE OF DEATH: (Month) <u>5</u> (Day) <u>11</u> (Year) <u>1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married Aug 19-1891</u>	8. DATE OF BIRTH: <u>Aug 19-1891</u>	9. AGE last birthday: <u>63</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, and if retired): <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Crown-Lock Co.</u>		11. BIRTHPLACE (State or foreign country): <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>JOSEPH V. Klemstein</u>				14. MOTHER'S MAIDEN NAME: <u>Rosalie M. Sunday</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Minnie Klemstein (Same)</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) <u>Coronary Occlusion</u>						1 1/2 days	
Antecedent cause(s) (b) <u>Coronary artery disease</u>						1 1/2 yrs	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>Dec 23, 1953</u>				19b. MAJOR FINDINGS OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE		INJURY					
HOMICIDE							
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Not while work <input type="checkbox"/> at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <u>Dec 23, 1953</u> , to <u>Apr 12, 1955</u> , that I last saw the deceased alive on <u>Apr 12, 1955</u> , and that death occurred at <u>8:50 P</u> m., from the causes and on the date stated above.							
SIGNATURE <u>Joseph Frank MD</u>				(DEGREE OR TITLE) ADDRESS <u>Balto 21 423 Eastern Ave Md</u>		DATE SIGNED <u>5/13/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>5-14-55</u>		NAME OF CEMETERY, OR CREMATORY <u>Meadowdale Cemetery</u>		LOCATION (City, town, or county) (State) <u>Balto. Md</u>	
DATE REC'D BY LOCAL REG. <u>5/14/55</u>		REGISTRAR'S SIGNATURE <u>Edith Hurley</u>		24. FUNERAL DIRECTOR <u>John J. Connelly</u>		ADDRESS <u>Essex, Md.</u>	

RECEIVED

MAY 17 1955

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

04404

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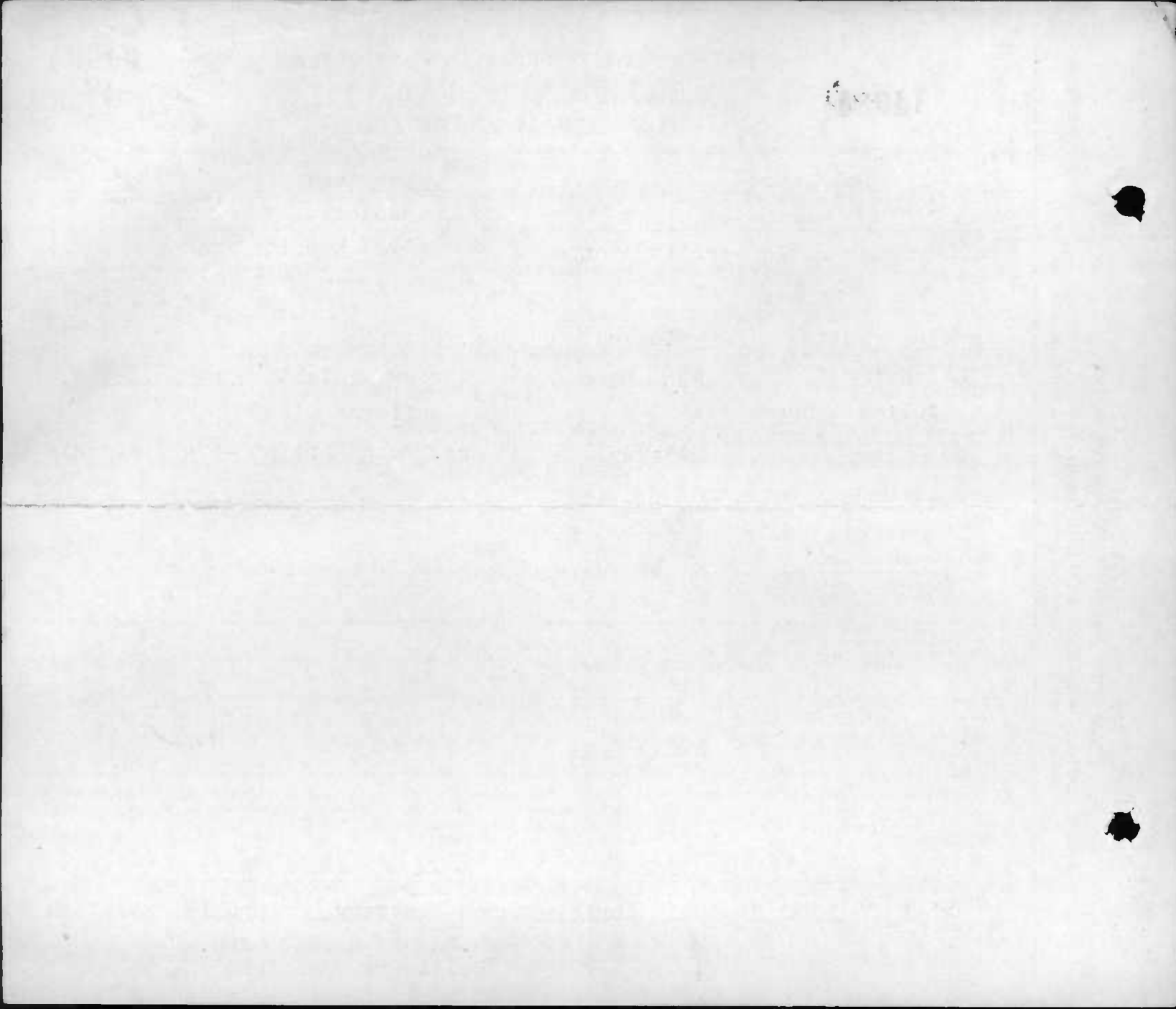
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 41

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Dundalk		CITY (If outside corporate limits, write RURAL and give nearest town) Dundalk	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1923 Merritt Avenue		STREET ADDRESS 1923 Merritt Avenue	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) MINNIE KONOPKA		4. DATE OF DEATH (Month) (Day) (Year) May 27, 1955	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. Widowed	8. DATE OF BIRTH Aug. 20, 1889
9. AGE last birthday 65 yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at Home	
11. BIRTHPLACE (State or foreign country) Warsaw, Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Julius Abramowski		14. MOTHER'S MAIDEN NAME Juliana Olko	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-03-3163	
17. INFORMANT Mrs. Ruth Martino -1743 Portship Rd		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause 420.1 Coronary Occlusion			
Antecedent cause(s) Hypertensive Cardio-Vascular Disease			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office hldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE M. J. Davis		DATE SIGNED 5/28/55	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF May 30, 1955	
NAME OF CEMETERY OR CREMATORY Christ Church Cemetery		LOCATION (City, town, or county) (State) Dundalk, Maryland	
DATE REC'D BY LOCAL REG. 5-31-55		REGISTRAR'S SIGNATURE A. W. Hedrick	
24. FUNERAL DIRECTOR H. SANDER & SONS, INC.		ADDRESS Baltimore, Maryland	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BUREAU V. S.

MAY 9 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4426 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04496 Reg. Dist.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 45

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Balto.</i>		MARYLAND		STATE		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (If this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <i>Essey, Balto.</i>		<i>5 yrs.</i>		TOWN <i>Rome.</i> 54			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>801 Brunswick Rd.</i>				STREET ADDRESS (If rural, give location) <i>1</i>			
3. NAME OF DECEASED: (Type or Print) <i>Chester Hager Lunsford</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>May 8 1955</i>			
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH: <i>Oct 13/1880</i>	9. AGE last birthday: <i>74</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <i>North Carolina.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <i>Raurence Hager</i>				14. MOTHER'S MAIDEN NAME: <i>Rachel Randall</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <i>Mrs. Sarah Goforth (Daughter).</i>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <i>Coronary occlusion</i>							
DUE TO							
Antecedent cause(s) (b) <i>Carcinomatosis general.</i>							
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c) <i>Carcinoma of Thyroid</i>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) <i>May 8 - 5:55 PM</i>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE: <i>M. D.</i>				DATE SIGNED: <i>May 9 1955</i>			
23. BURIAL, CREMATION, REMOVAL (Specify): <i>REMOVAL</i>		DATE THEREOF: <i>MAY 9, 1955</i>		NAME OF CEMETERY OR CREMATORY: <i>MACE DONIA CEM.</i>		LOCATION (City, town, or county) (State): <i>ASHEVILLE, N. CAR.</i>	
DATE REC'D BY LOCAL REG: <i>5-9-55</i>		REGISTRAR'S SIGNATURE: <i>R. W. ...</i>		24. FUNERAL DIRECTOR: <i>Wm Cook-Blight, Inc.</i>		ADDRESS: <i>6009 HARFORD Rd.</i>	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4427 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

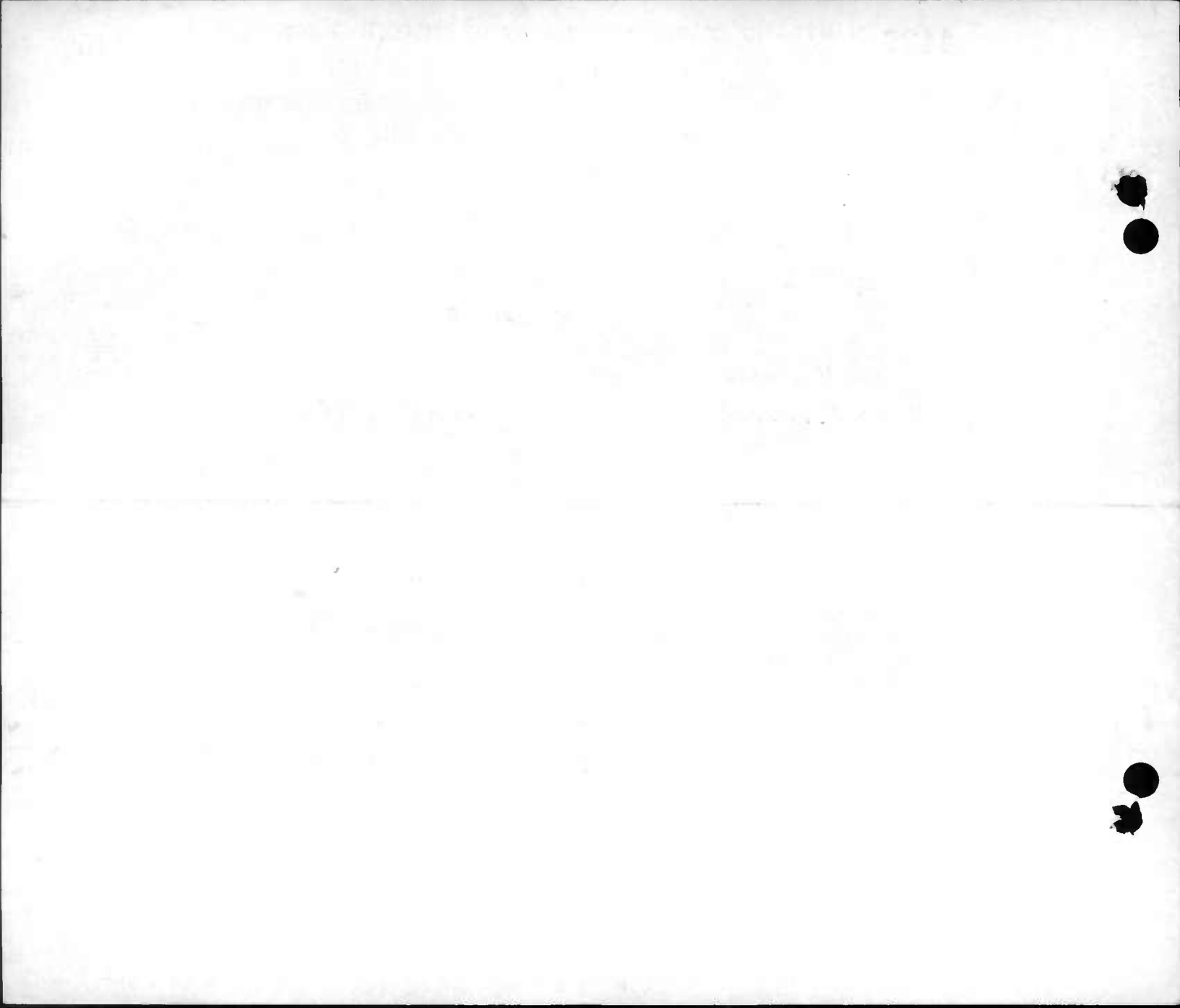
04407

CERTIFICATE OF DEATH

Reg. Dist. No.

Item 9, FilmG182 6-6-55 et

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTO.		MARYLAND		STATE MD.		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN CATONSVILLE				TOWN BALTO.		3V01-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 16 FUSTING AVE.				STREET ADDRESS (If rural give location) 528 TUNBRIDGE RD.			
3. NAME OF DECEASED: (First) GEORGE (Middle) W. (Last) LYNCH				4. DATE OF DEATH: (Month) MAY (Day) 31 (Year) 1955			
5. SEX: M		6. COLOR OR RACE: W		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWER		8. DATE OF BIRTH: 8-17-83	
9. AGE last birthday: 71 yrs.		10. KIND OF BUSINESS OR INDUSTRY: U.S. GOVT.		11. BIRTHPLACE (State or foreign country): MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: WILLIAMS, LYNCH				14. MOTHER'S MAIDEN NAME: SARA H. MCNEAL			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: KENNETH LYNCH	
18. MEDICAL CERTIFICATION				Interval Between Onset And Death			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause (a) Cerebral Hemorrhage				1 wk.			
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Chs. Hypertensive Cardiovascular-Renal Disease				10 yrs.			
(c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: 0				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6-18-1952 , to 5-31-1955 , that I last saw the deceased alive on 5-31-1955 , and that death occurred at 6:30 A.M. , from the causes and on the date stated above.							
SIGNATURE William K. Gallagher M.D.				ADDRESS 6209 Frederick Rd., Balt. 28, Md.			
23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		DATE THEREOF 6-2-1955		NAME OF CEMETERY OR CREMATORY PARKWOOD		LOCATION (City, town, or county) (State) BALTO. Co. MD.	
DATE REC'D BY LOCAL REGISTRAR 6-1-55		REGISTRAR'S SIGNATURE H. W. Jenkins		24. FUNERAL DIRECTOR H.W. JENKINS & SONS Co.		ADDRESS 4905 YORK RD. BALTO. 12, MD.	



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04408

4335

CERTIFICATE OF DEATH

Reg. Dist. No. 11

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Bal To</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk 22</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>731 N. Avondale Rd.</u>		STREET ADDRESS (If rural, give location) <u>731 N. Avondale Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>Eddie</u> (First) (Middle) (Last) <u>MACON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 17, 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>May 18, 1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Longshoreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SHIPPING FIRMS</u>	9. AGE last birthday <u>61</u> yrs. If under 1 year Months <u>2</u> Days <u>9</u> If under 24 hrs. Hours <u>-</u> Min. <u>-</u>
11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Ed Green</u>		14. MOTHER'S MAIDEN NAME <u>Rosa ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>World War</u>		16. SOCIAL SECURITY NO. <u>213-01-5979</u>	
17. INFORMANT AND ADDRESS <u>Liztie Macon 731 N. Avondale Rd.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

725X Immediate cause (a) UREMIA2 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) PNEUMONIA, Hypostatic3 days(c) ARTHRITIS3 years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at ☐ Not While Work ☐ At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 20, 1954, to May 17, 1955, that I last saw the deceasedalive on May 17, 1955, and that death occurred at 9:08 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

William C. Stedman, M.D. 140 Oak Ave., Dundalk 22, Md. May 17, 1955

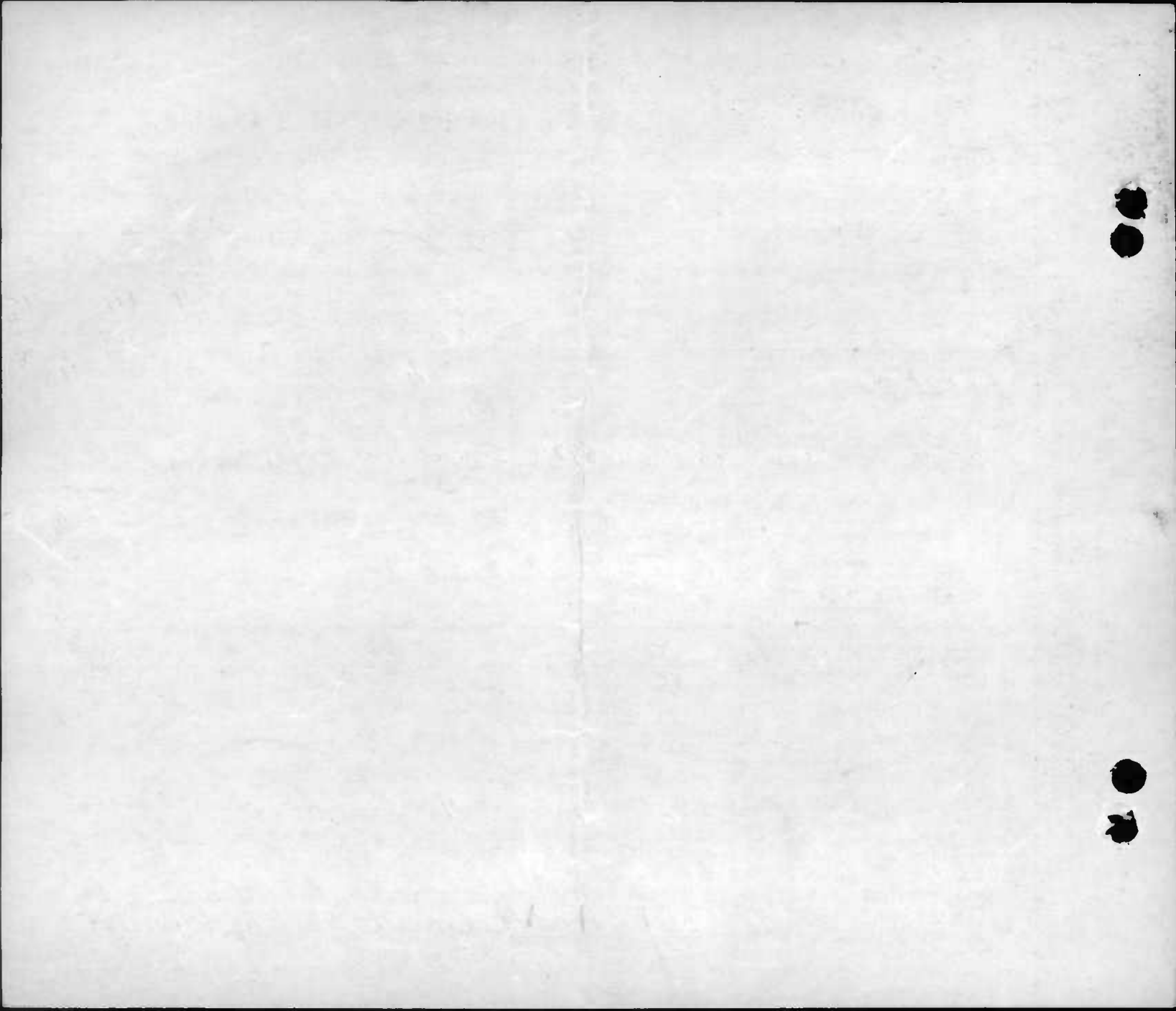
23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 5/20/55 NAME OF CEMETERY OR CREMATORY BALTIMORE MARSHALL LOCATION (City, town, or county) (State) BALTIMORE, MD.

DATE REC'D BY LOCAL REG. 5-19-55 REGISTRAR'S SIGNATURE EVERGREEN FUNERAL DIRECTOR CHARLES K. LAW, 802 Madison Ave. ADDRESS ETERSBURG, VA.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4428

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

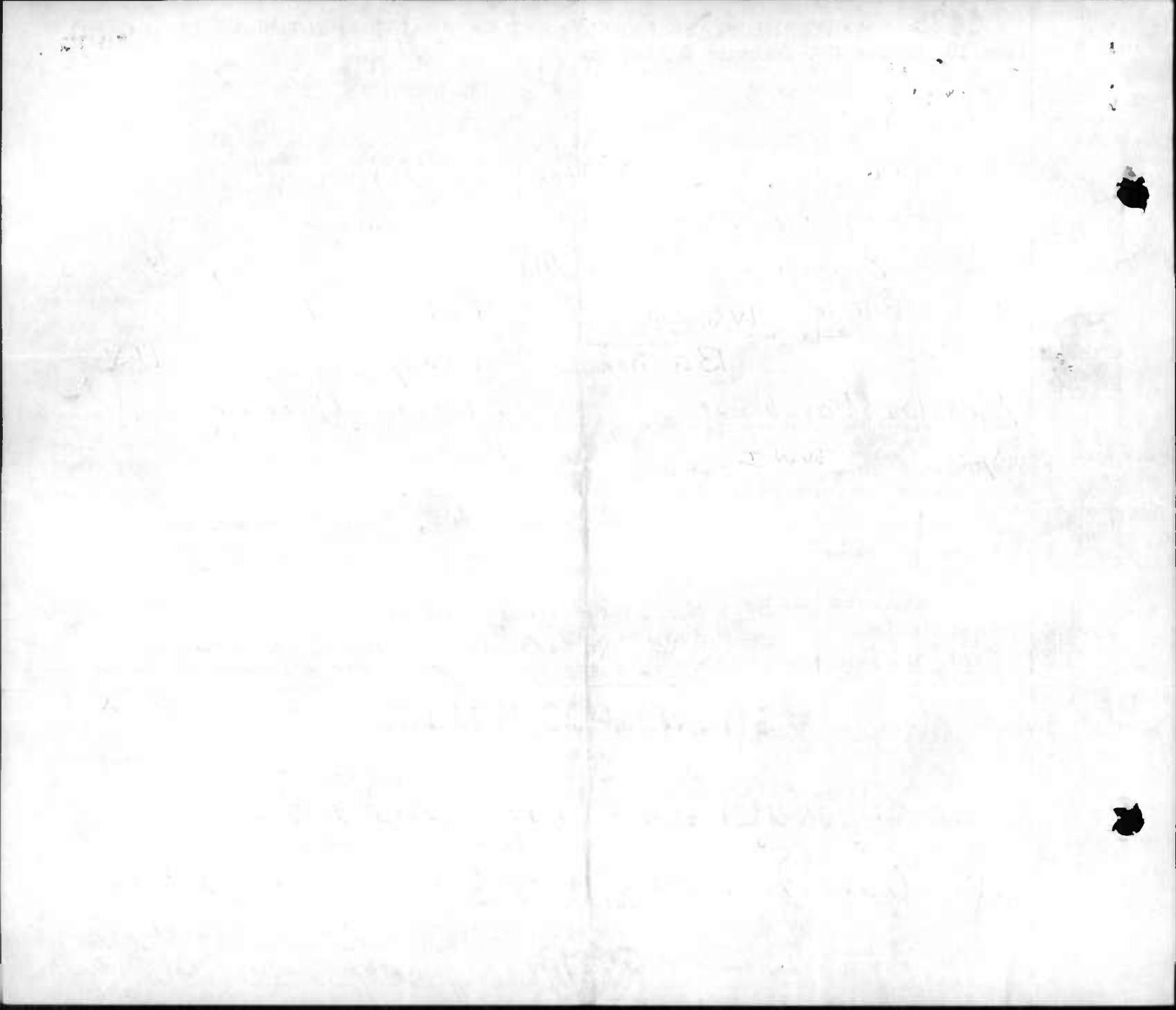
04409

Item 18 ByPhone: Dr. Newcomer 6/8/55 am

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Mt Wilson Md</u> TOWN <u>3 Days</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt Wilson State Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Prince George</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hyattsville</u> <u>16-15-2</u> STREET ADDRESS (If rural give location) <u>2720 Kirkwood Place</u>	
3. NAME OF DECEASED: (Type or Print) <u>Benjamin</u> (First) <u>Marchione</u> (Middle) (Last) 4. DATE (Month) (Day) (Year) OF DEATH: <u>May</u> <u>3</u> <u>1955</u>		5. SEX: <u>Male</u> 6. COLOR OR RACE: <u>White</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u> 8. DATE OF BIRTH: <u>3-7-1888</u> 9. AGE last birthday <u>67</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Barber</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Italy</u>	
11. BIRTHPLACE (State or foreign country): <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Nicholas Marchione</u>		14. MOTHER'S MAIDEN NAME: <u>Eleanor Catuti</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT & ADDRESS: <u>Hospital Records</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>OIOX</u> IMMEDIATE CAUSE ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (A) <u>1 Meningitis, acute tubercular</u> DUE TO (B) <u>2 Pneumonitis acute, diffu</u> DUE TO (C) <u>3 Nephritis chronic</u>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Pulmonary tuberculosis</u>			
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-29</u> , 19 <u>54</u> , to <u>5-3</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-3</u> , 19 <u>55</u> , and that death occurred at <u>1145 AM</u> , from the causes and on the date stated above. SIGNATURE <u>William Newcomer</u> ADDRESS <u>M.D. Mt Wilson Md</u> DATE SIGNED <u>5-3-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>5-5-55</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington National</u> LOCATION (City, town, or county) (State) <u>Arlington Va</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/9/55</u>		REGISTRAR'S SIGNATURE <u>Amanda L. Newcomer</u>	
24. FUNERAL DIRECTOR <u>Lumky Hannon</u>		ADDRESS <u>3831 - Palmer Dr. DC</u>	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

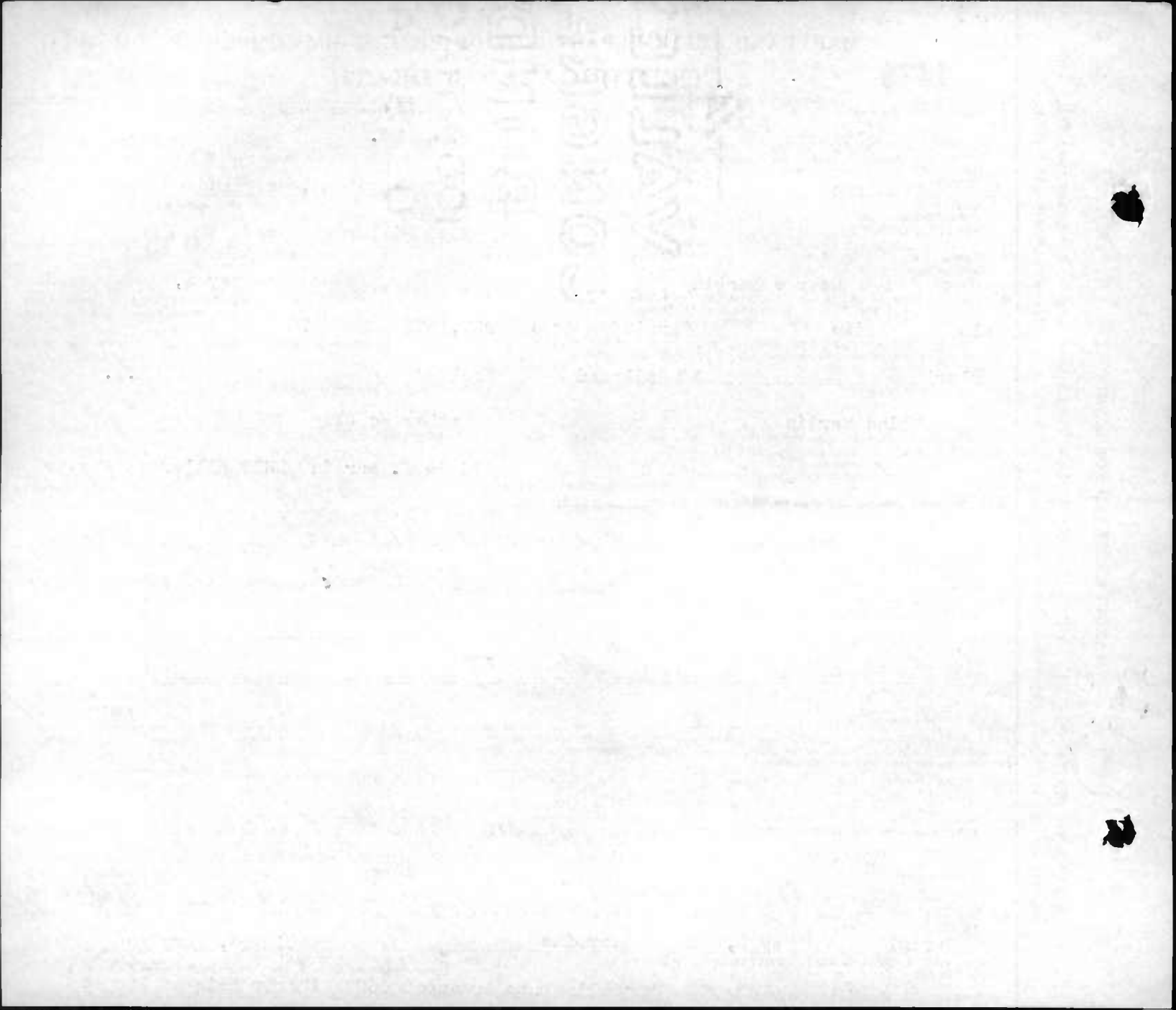
04410

4429

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Woodlawn, Maryland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>20</u>				<u>2008 Hillcrest Avenue</u>			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(Type or Print) <u>George Martin</u>				OF DEATH: <u>May 5,</u> <u>19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>November 27, 1875</u>	<u>79</u> yrs.	Months	Days	Hours Mln.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Clerk</u>		<u>B&O Railroad</u>		<u>Ireland</u>		<u>U.S.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Allan Martin</u>				<u>Esther McCully</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>9</u>				<u>Addie P. Martin 2008 Hillcrest Avenue</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Myocardial Degeneration</u>						<u>4 years</u>	
ANTECEDENT CAUSE (S) (B) <u>Atherosclerotic Cardiovascular Disease</u>						<u>10 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						(C) <u>Senility</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
<u>no operation</u>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 16, 1951</u> , to <u>May 5, 1955</u> , that I last saw the deceased alive on <u>May 4, 1955</u> , and that death occurred at <u>6 P.</u> M, from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Joshua H. Armacost</u>		<u>M. D. 6419 Windsor Mill Rd</u>		<u>5/6/55 me</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 9, 1955</u>		<u>Lorraine</u>		<u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR			
<u>5-6-55</u>		<u>A. W. H.</u>		<u>Ellsworth Armacost</u>			
				<u>4600 Liberty Heights Avenue</u>			



4336

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

04411

Reg. Dist. No. 41

1. PLACE OF DEATH - COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>MD</u> COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>53 DUNDALK (22)</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>53 DUNDALK 22</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>39 Northship Rd</u>		STREET ADDRESS (If rural, give location) <u>39 NORTHSHIP RD.</u>	
3. NAME OF DECEASED (First) <u>HENRY</u> (Middle) <u>EDGAR</u> (Last) <u>MC BRIDE</u>	4. DATE OF DEATH (Month) <u>5</u> (Day) <u>22</u> (Year) <u>55</u> 19		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>3-5-1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TURNER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL MFR</u>	9. AGE last birthday <u>82</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>ENGLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>U.K.</u>	
13. FATHER'S NAME <u>PETER MC BRIDE</u>		14. MOTHER'S MAIDEN NAME <u>SUSANNAH RICHARDS</u>	
15. WAS DECEASED EVEN IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>01307-0299</u>	
17. INFORMANT AND ADDRESS <u>MRS. JAMES O. CHILDS</u>		<u>RUSSELL, KY.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
422.1 Immediate cause (a) <u>Arteri-Sclerotic Cardio Vascular Disease</u>		<u>10 yrs</u>
Antecedent cause(s) (b) <u>Remedy</u>		
(c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Home</u> (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE <u>W. B. Davis M.D.</u>	DATE SIGNED <u>5/23/55</u>
23. BURIAL - CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>5-26-55</u>
NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	LOCATION (City, town, or county) (State) <u>Rocky, Md.</u>
DATE REC'D BY LOCAL REG. <u>May 24-1955</u>	24. FUNERAL DIRECTOR <u>Walter B. Bradley, Dundalk, Md.</u>
REGISTRAR'S SIGNATURE <u>William M. Kelly</u>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 26 1955

BUREAU V. S.

4430

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04412
Reg. Dist.

No. 32

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore	MARYLAND	STATE Maryland	COUNTY Prince George's
X CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Mt. Wilson		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Edmonston	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Mt. Wilson State Hospital		STREET ADDRESS (If rural, give location) 5114 Decatur Street	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First)	(Middle)	(Last)	(Month) (Day) (Year)
Bell Patrick McFarland		5 5 19 55	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):	8. DATE OF BIRTH:
Male	White	Single	12/5/03
9. AGE last birthday:		IF UNDER 1 YEAR	
51		Months Days	
		5 8	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:	
Painter		Painting	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Hyattsville, Md.		U.S.	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
George M. McFarland		Catherine Fowler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:	
Yes		577-18-0439	
17. INFORMANT & ADDRESS:			
Hospital records			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH
002 X Immediate cause (a) Pulmonary Tuberculosis; Far Advanced DUE TO Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)		Approx. 1 year
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
None.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY?
2		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	21c. (City or town) (County) (State)
None	None	None
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
None	M.	None
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE A. D. Caples		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 5-6-55
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
		ASSISTANT MEDICAL EXAM. <input type="checkbox"/>
23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
REMOVAL	MAY 7, 1955	EVERGREEN CEMETERY
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR
MAY 6, 1955	Martha A. Newell	FRANCIS GASCH'S SONS
		ADDRESS HYATTSVILLE MD

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 12 1955
BUREAU V. S.

BUREAU V. S.

MAY 12 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04413

4431

CERTIFICATE OF DEATH

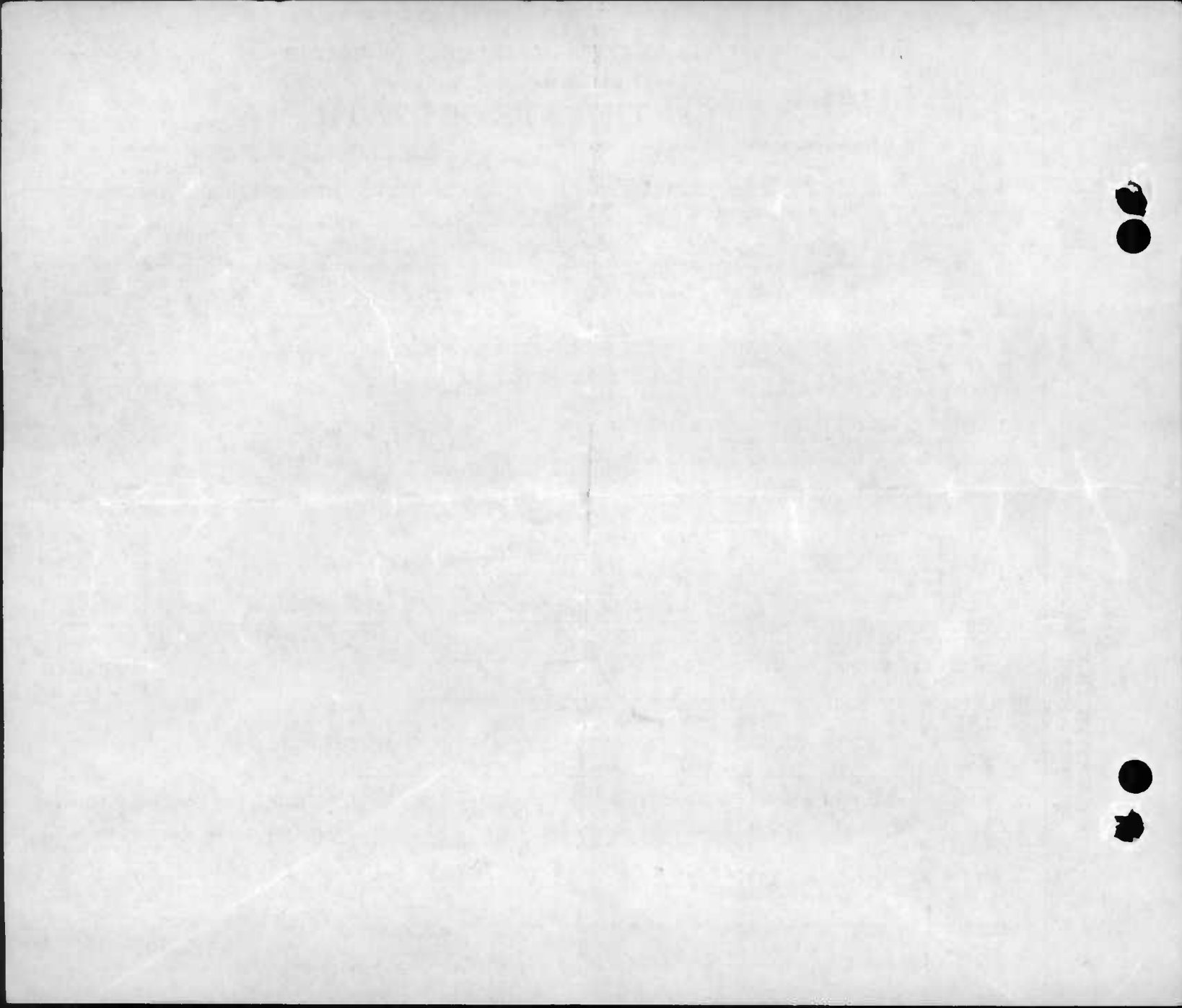
Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Port Howard P.O.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>u</u>	
TOWN <u>u</u>		TOWN <u>u</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Old Bay Rd + Todd Ave</u>		STREET ADDRESS (If rural, give location) <u>#1.</u>	
3. NAME OF DECEASED (Type or Print) <u>Thomas Wade Melton</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>25</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 7, 1919</u>
9. AGE last birthday <u>35</u> yrs. <u>75</u> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.		10. DATE OF BIRTH	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Wm. W. Melton (son) as in #1</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
4224 Immediate cause (a) <u>arteriosclerosis</u>			<u>10 yrs</u>
Antecedent cause(s) (b) <u>+ chronic myocarditis</u>			<u>10 yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>chronic asthma + pulmonary emphysema</u>			<u>4 yrs</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office hldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Aug 1</u> , 19 <u>53</u> to <u>May 25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 19</u> , 19 <u>55</u> , and that death occurred at <u>11 30 P</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Thomas H. Hallin, M.D.</u>		DATE SIGNED <u>5/25/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
DATE REC'D BY LOCAL REG. <u>5/27/55</u>		REGISTRAR'S SIGNATURE <u>Wm. W. Melton</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>Howard County Md</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4432

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04414

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 33

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Reisterstown(rural)</u>		<u>13 yrs</u>		TOWN <u>Reisterstown(rural)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Butler Road</u>				STREET ADDRESS (If rural, give location) <u>Butler Road</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>Paul</u>		(Middle) <u>Eugene</u>		(Last) <u>Merkel</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>Mar. 12, 1910</u>	
9. AGE last birthday: <u>45</u> yrs.		4. DATE OF DEATH: <u>May 12</u>		(Month) <u>12</u>		(Year) <u>19 55</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Equip. Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Md. State Roads</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore City, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Walter E. Merkel</u>				14. MOTHER'S MAIDEN NAME: <u>Ruth Zahn</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		(If Yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Mrs. Margaret E. Merkel, Reisterstown, Md</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Angina Pectoris</u>						<u>8 hrs.</u>	
DUE TO							
Antecedent cause(s) (b) <u>none</u>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>none</u>							
19a. DATE OF OPERATION: <u>none</u>		19b. MAJOR FINDING OF OPERATION: <u>none</u>				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>none</u>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>none</u>		21c. (City or town) <u>none</u>		(County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>none</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>none</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>D. D. Caples</u>		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED <u>5-16-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>5-15-55</u>		NAME OF CEMETERY OR CREMATORY <u>Jessops Methodist</u>		LOCATION (City, town, or county) (State) <u>Sparks, Md.</u>	
DATE REC'D BY LOCAL REG. <u>5-15-55</u>		REGISTRAR'S SIGNATURE <u>Mary B. Eline</u>		24. FUNERAL DIRECTOR <u>Brooks Funeral Service, Sparks, Md.</u>		ADDRESS	

RECEIVED

MAY 23 1955

BUREAU V. S.

6-12-22 (of 100) B. Jones

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18441544

4433

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>FORT HOWARD</u>		LENGTH OF STAY (in this place) <u>3 DAYS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>1331 BRUNT STREET</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>WILLIAM H. MICKEY</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>MAY 5 1955</u>			
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>COLORED</u>	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>12-19-24</u>	9. AGE last birthday <u>30</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>JANITOR</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>PRIVATE CONCERN</u>		11. BIRTHPLACE (State or foreign country): <u>BALTIMORE, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY: <u>U. S. A.</u>	
13. FATHER'S NAME: <u>ERNEST MICKEY</u>				14. MOTHER'S MAIDEN NAME: <u>AMY CROMWELL</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>YES</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>220-11-8197</u>		17. INFORMANT & ADDRESS: <u>CLIN.REC., VET.ADM.HOSP., FT.HOWARD, MD.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>FATTY LIVER WITH CIRRHOSIS; JAUNDICE.</u>						UNKNOWN	
ANTECEDENT CAUSE (S): DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>ACUTE GASTRIC ULCER WITH MODERATE HEMORRHAGE</u>						UNKNOWN	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>2</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>VA</u> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>MAY 2</u> , 19 <u>55</u> , to <u>MAY 5</u> , 19 <u>55</u> , and that death occurred at <u>1:40</u> M, from the causes and on the date stated above.							
SIGNATURE <u>WILLIAM B. VANDEGRIET, M.D.</u>				ADDRESS <u>M.D.VAH, FORT HOWARD, MARYLAND 5-6-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>5-8-55</u>		NAME OF CEMETERY OR CREMATORY <u>ARBUTUS MEMORIAL PARK CEMETERY</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 7, 1955</u>		REGISTRAR'S SIGNATURE <u>RW</u>		24. FUNERAL DIRECTOR <u>Arlington S. Phillips, 1808 N. Monroe St. Baltimore 17, Md.</u>			

CERTIFICATE OF NATURALIZATION

NO. 100,000

UNITED STATES DEPARTMENT OF JUSTICE

IMMIGRATION AND NATURALIZATION SERVICE

WASHINGTON, D. C. 20535

FILE NO. 100-100000

DATE OF NATURALIZATION

BY WHOM NATURALIZED

AT WHAT PLACE

IN WHAT COURT

AND IN WHAT CITY

STATE OF

COUNTY OF

CITY OF

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

EMPLOYMENT

RELIGION

POLITICAL OPINION

CHARACTER

TESTIMONY

SWORN TO

SUBSCRIBED

ATTEST

BY

IN WITNESS WHEREOF

I have hereunto set my hand and the seal of the

Department of Justice at Washington, D. C.

this 10th day of

1900

UNITED STATES DEPARTMENT OF JUSTICE

IMMIGRATION AND NATURALIZATION SERVICE

WASHINGTON, D. C. 20535

FILE NO. 100-100000

DATE OF NATURALIZATION

BY WHOM NATURALIZED

AT WHAT PLACE

IN WHAT COURT

AND IN WHAT CITY

STATE OF

COUNTY OF

CITY OF

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

EMPLOYMENT

RELIGION

POLITICAL OPINION

CHARACTER

TESTIMONY

SWORN TO

SUBSCRIBED

ATTEST

BY

IN WITNESS WHEREOF

I have hereunto set my hand and the seal of the

Department of Justice at Washington, D. C.

this 10th day of

1900

UNITED STATES DEPARTMENT OF JUSTICE
IMMIGRATION AND NATURALIZATION SERVICE
WASHINGTON, D. C. 20535
FILE NO. 100-100000
DATE OF NATURALIZATION
BY WHOM NATURALIZED
AT WHAT PLACE
IN WHAT COURT
AND IN WHAT CITY
STATE OF
COUNTY OF
CITY OF
DATE OF BIRTH
PLACE OF BIRTH
EDUCATION
EMPLOYMENT
RELIGION
POLITICAL OPINION
CHARACTER
TESTIMONY
SWORN TO
SUBSCRIBED
ATTEST
BY
IN WITNESS WHEREOF
I have hereunto set my hand and the seal of the
Department of Justice at Washington, D. C.
this 10th day of
1900

4434

CERTIFICATE OF DEATH

04416
Reg. Dist. No. 3

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Rural - Randallstown</u>				OR TOWN <u>Rural - Randallstown</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Holbrook</u>				STREET ADDRESS (If rural give location) <u>Holbrook</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Mary S. Moffett</u>				OF DEATH: <u>May 7</u> 19 <u>55</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Sept. 2, 1868</u>	9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife own home</u>				10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Thomas Kelley</u>				14. MOTHER'S MAIDEN NAME: <u>Virginia Brooks</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS: <u>Mr. H. T. Moffett - Randallstown, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>						<u>1 wk</u>	
ANTECEDENT CAUSE (S) DUE TO (B) <u>Cardio-vascular disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/1/55</u> , 19 <u>55</u> , to <u>5/7/</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/6/</u> , 19 <u>55</u> , and that death occurred at <u>5:10 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Mr. E. Martin</u>				ADDRESS <u>M. D. Randallstown</u>		DATE SIGNED <u>5/7/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-9-55</u>		NAME OF CEMETERY OR CREMATORY <u>Wards Chapel</u>		LOCATION (City, town, or county) (State) <u>Baltimore Co., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/7/55</u>		REGISTRAR'S SIGNATURE <u>Mr. E. Martin</u>		24. FUNERAL DIRECTOR <u>Lucius H. Haight - Hyattsville, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 10 1955

BUREAU V. S.

M

MARYLAND

4346

CERTIFICATE OF DEATH

04417

STATE DEPARTMENT OF HEALTH

Reg. Dist. No.....

1. PLACE OF DEATH- COUNTY BALTO COUNTY MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MD COUNTY BALTO CT	
CITY (If outside corporate limits, write RURAL and give nearest town) ROSEMONT		CITY (If outside corporate limits, write RURAL and give nearest town) ROSEMONT	
HOSPITAL OR INSTITUTION OR STREET ADDRESS ✓		STREET ADDRESS (If rural, give location) 3010 ALABAMA AVE	
3. NAME OF DECEASED (Type or Print) ANNIE M. MYERS (First) (Middle) (Last)		4. DATE OF DEATH 5-18-1955 (Month) (Day) (Year)	
5. SEX F	6. COLOR OF RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, OR SEPARATED (Specify) WIDOWED	8. DATE OF BIRTH FEB 10 1882 (Month) (Day) (Year)
9. AGE last birthday 73 yrs. 3 mos. 0 hrs. 0 min.		10. BIRTHPLACE (State or foreign country) BALTO	
11. USUAL OCCUPATION (Give kind of work done during life, even if retired) NONE		12. CITIZEN OF WHAT COUNTRY? NOT KNOWN	
13. FATHER'S NAME LEONARD MARTIN		14. MOTHER'S MAIDEN NAME NOT KNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ✓		16. SOCIAL SECURITY No. ✓	
17. INFORMANT AND ADDRESS MRS GETZ 3010 ALABAMA AVE		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) Coronary Occlusion		24 hours	
Antecedent cause(s) (b) Generalized Arteriosclerosis		unknown	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION 0		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1-4-55 , 19....., to 5-18-55 , 19....., that I last saw the deceased alive on 5-17-55 , 19....., and that death occurred at 10⁰⁰ A. m., from the causes and on the date stated above.			
SIGNATURE Nathan R. Guein (Degree or title)		DATE SIGNED 5-20-55	
ADDRESS 206 S. Gilmer ST			
23. BURIAL, CREMATION, OR OTHER DISPOSITION BURIAL		NAME OF CEMETERY OR CREMATORY WESTERN	
DATE REC'D BY LOCAL REG. 5-20-55		FUNERAL DIRECTOR ADDRESS GEO. LEIMBACH 525 N. LYNDA HURST ST	

MARGIN RESERVED FOR BINDING

I

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4435

CERTIFICATE OF DEATH

Reg. Dist. No.

044184

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>FORT HOWARD</u>		LENGTH OF STAY (in this place) <u>37 DAYS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>REISTERSTOWN</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>DOVER ROAD</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>EDWARD C. MYERS</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>MAY 11 1955</u>			
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH: <u>11-20-97</u>	9. AGE last birthday <u>57</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 Hrs. Days	IF UNDER 60 Min. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>POSTAL CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>RAILWAY</u>		11. BIRTHPLACE (State or foreign country): <u>BORING, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>JOHN E. MYERS</u>				14. MOTHER'S MAIDEN NAME: <u>ANNIE CROWTHER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>YES WW I</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>CLIN.REC., VET.ADM.HOSP.FT.HOWARD, MD.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>451X ANEURYSM OF POSTERIOR COMMUNICATING CEREBRAL ARTERY</u>						UNKNOWN	
ANTECEDENT CAUSE (S): <u>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>Approx. 2-25-55</u>				19b. MAJOR FINDINGS OF OPERATION: <u>Ligation of aneurysm and branches of right middle cerebral artery.</u>			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>VA M.</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>APR. 4, 1955</u> , to <u>MAY 11, 1955</u> , that I saw the deceased <u>and that death occurred at 7:40 P.M. from the causes and on the date stated above.</u>							
SIGNATURE <u>William E. VandeGrift, M.D.</u>				ADDRESS <u>M. D. VAH, FORT HOWARD, MARYLAND</u> DATE SIGNED <u>5-12-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 15-55</u>		NAME OF CEMETERY OR CREMATORY <u>PLEASANT GROVE CEMETERY</u>		LOCATION (City, town, or county) (State) <u>REISTERSTOWN, MARYLAND</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 16-55</u>		REGISTRAR'S SIGNATURE <u>Dawson L. Harbor</u>		24. FUNERAL DIRECTOR ADDRESS <u>Tipton Funeral Home, R Hampstead, Md.</u>			

RECEIVED

MAY 18 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4436 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 325

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Balto</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Catonsville</u>	LENGTH OF STAY (in this place) <u>Sept 2-16-53</u>	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Catonsville Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>1201 Elm Ridge Ave</u>	
3. NAME OF DECEASED: (Type or Print) <u>Alice Neilson</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 24 1953</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>9-22-1880</u>
9. AGE last birthday: <u>74</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if <u>housewife</u>)		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country): <u>Balto Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Patrick Horn</u>		14. MOTHER'S MAIDEN NAME: <u>Margaret Holland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>9</u> (If Yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY No.: <u>-</u>	
17. INFORMANT & ADDRESS: <u>1201. Ave</u> <u>Care of Toelle Elmridge</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
422.1 Immediate cause (a) <u>Cardiac Decomposition</u> DUE TO			
Antecedent cause(s) (b) <u>active sclerotic Cardiac</u> DUE TO			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>vascular disease</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>fracture of hip July 53</u>			
19a. DATE OF OPERATION: <u>6</u>		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>Geo M Kieffer</u>		DATE SIGNED <u>May 25 1953</u>	
CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		M. D. <u>May 25 1953</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>5/24/53</u>	NAME OF CEMETERY OR CREMATORY: <u>Landon Park Cem.</u>	LOCATION (City, town, or county) (State): <u>3801 Frederick Ave</u>
DATE REC'D BY LOCAL REG: <u>5-26-53</u>	REGISTRAR'S SIGNATURE: <u>Geo M Kieffer</u>	24. FUNERAL DIRECTOR: <u>John J. Connerlyon</u>	

ant. last
period

4437

CERTIFICATE OF DEATH

Reg. Dist. No. 04420

1. PLACE OF DEATH:

COUNTY BALTIMORE MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWSON 4. LENGTH OF STAY (in this place) 10 years
 HOSPITAL OR INSTITUTION OR STREET ADDRESS SHEPARD AND ENDICOTT PRATT HOSPITAL TOWSON 4, MD.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLAND COUNTY TALBOT
 CITY (If outside corporate limits, write RURAL and give nearest town) EASTON
 STREET ADDRESS (If rural give location) 20-40-2

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

HELENTHROPNICHOLSON

4. DATE OF DEATH:

(Month)

(Day)

(Year)

MAY271955

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR IF UNDER 24 HRS.
 Months Days Hours Min.

FEMALEWHITEWIDOWJUNE 10, 187084 yrs.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

HOUSEWIFEPITTSBURGH PENNAUSA.

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

JOHN MILLER THROPVALE VEEDEER.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

4 NoUNKHOSPITAL RECORDS.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1
 Immediate cause

(a)

CARDIO-VASCULAR FAILURE.

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

GENERALIZED ARTERIOSCLEROSIS

DUE TO

(c)

Interval Between Onset And Death

1 WEEK10 YEARS.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

None SENILE PSYCHOSIS

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

NoneNone.

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)
 OF INJURY None

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from UNK., 1952, to MAY, 1955, that I last saw the deceased alive on MAY 27, 1955, and that death occurred at 1:30 PM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

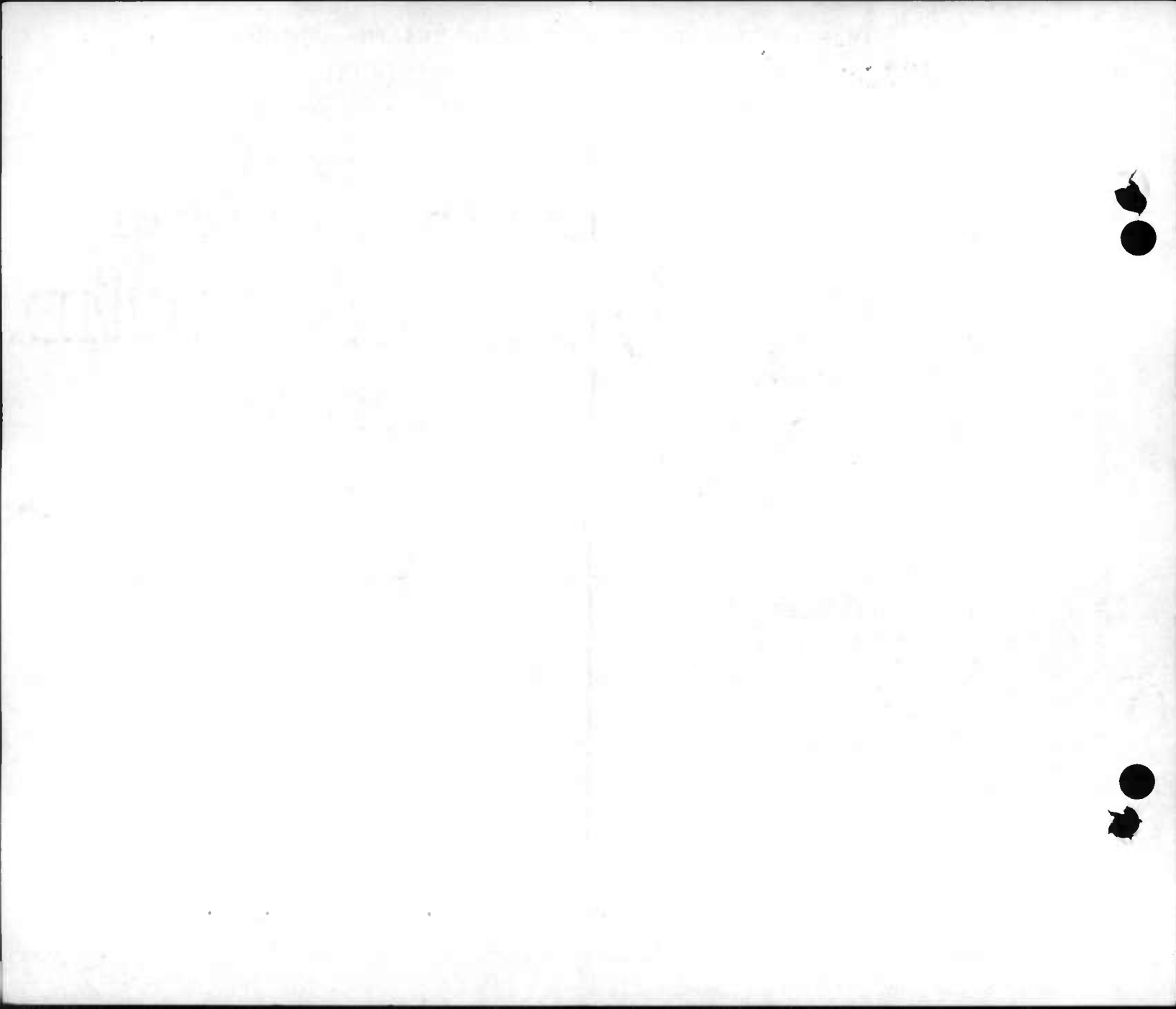
24. FUNERAL DIRECTOR

ADDRESS

May 28 1955R.W.Dr. J. V. Lickner & SonsBalto 17, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



4438

CERTIFICATE OF DEATH

Reg. Dist. No.

20.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Balto.		MARYLAND		STATE Md.		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 52 Catonsville		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 House in the Pines 16 Fusting Ave.				STREET ADDRESS (If rural give location) 1041 Ridgely St.			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
LILLIAN I. NUFFER				May 11, 1955			
5. SEX: female		6. COLOR OR RACE: white		7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): married		8. DATE OF BIRTH: June 6, 1889	
9. AGE last birthday: 65 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Inspector		11. BIRTHPLACE (State or foreign country): Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: James McKeldin				14. MOTHER'S MAIDEN NAME: Dora Grief			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)				17. INFORMANT & ADDRESS: Mr. Robert Nuffer - 1041 Ridgely St.			
16. SOCIAL SECURITY NO.							
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE 443X				Hypertensive Cardiovascular Systr			
ANTECEDENT CAUSE (S):				Disease			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 0				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 5/10/55 to 5/11/55 , that I last saw the deceased alive on 5/10/55 , and that death occurred at 8 AM , from the causes and on the date stated above.							
SIGNATURE John R. Sturo		M. D. 401 Med. Bldg.		DATE SIGNED 5/12/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 5/13/55		NAME OF CEMETERY OR CREMATORY Glen Haven Cem.		LOCATION (City, town, or county) (State) Glen Burnie, Md.	
DATE REC'D BY LOCAL REGISTRAR 5-13-55		REGISTRAR'S SIGNATURE W. Hedger		FUNERAL DIRECTOR Wm. J. Tucker & Sons		ADDRESS Balto Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES OF AMERICA

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF THE ASSISTANT SECRETARY FOR PUBLIC AFFAIRS

WASHINGTON, D.C. 20492

TELEPHONE (202) 205-2000

TELETYPE (202) 205-2000

FACSIMILE (202) 205-2000

MAIL ROOM (202) 205-2000

RECORDS MANAGEMENT (202) 205-2000

GENERAL INQUIRIES (202) 205-2000

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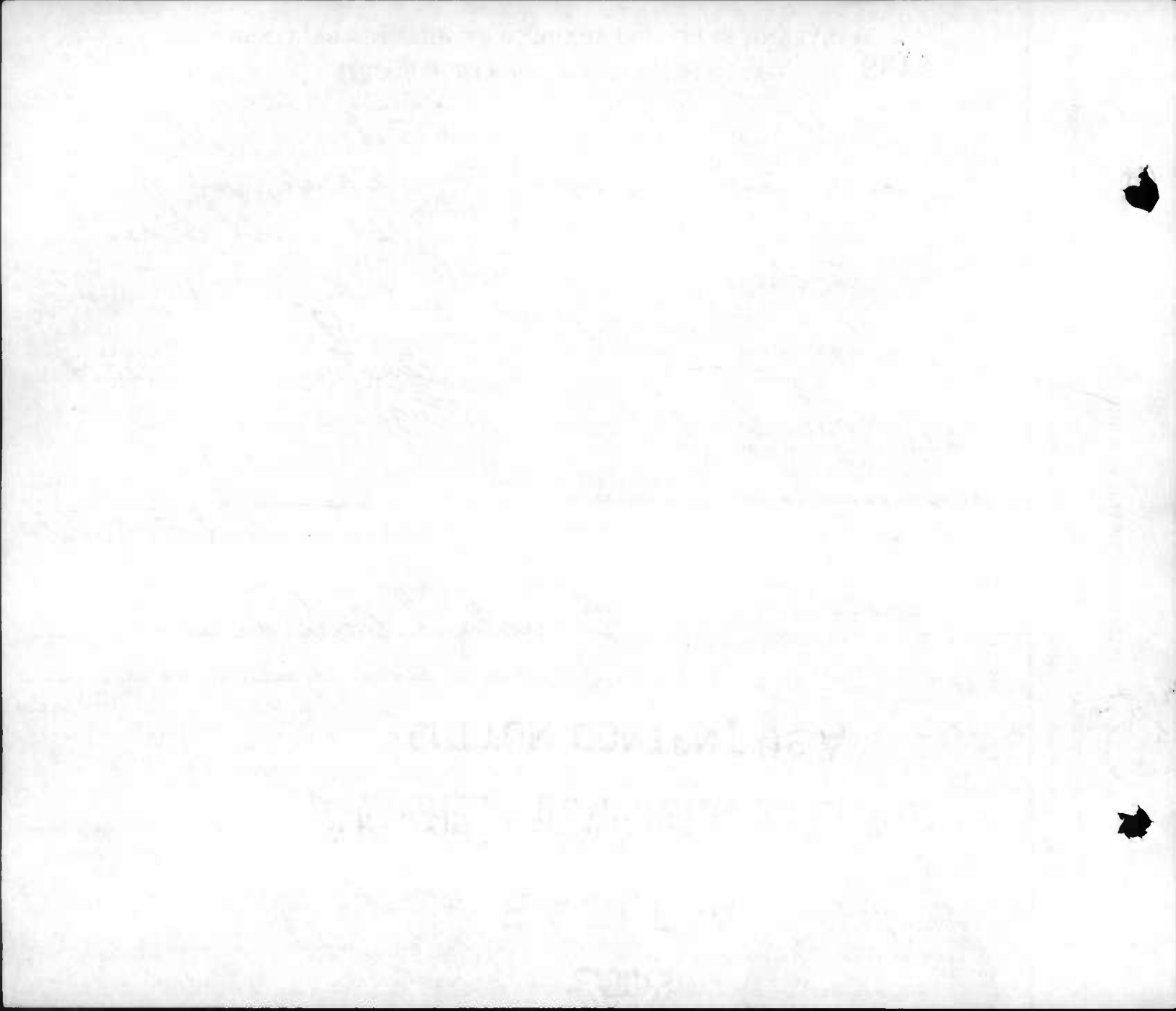
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4439

CERTIFICATE OF DEATH

Reg. Dist. No. 04422

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>54</u> TOWN <u>Essex, Md.</u>	LENGTH OF STAY (in this place) <u>70 yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>54</u> <u>Essex, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>160 Wiltshire Rd.</u>		STREET ADDRESS (If rural give location) <u>160 Wiltshire Rd.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Andrew</u> <u>OCHAB</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>May 7 1955</u>	
5. SEX: <u>M.</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>May 11-1875</u>
9. AGE last birthday: <u>79</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Austria</u>	11. CITIZEN OF WHAT COUNTRY? <u>USIA</u>
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		13. KIND OF BUSINESS OR INDUSTRY:	
14. FATHER'S NAME: <u>Joseph Ochab</u>		15. MOTHER'S MAIDEN NAME: <u>Regina</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		17. SOCIAL SECURITY NO. <u>—</u>	
18. MEDICAL CERTIFICATION		19. INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cerebro-vascular accident</u>		<u>sudden</u>	
ANTECEDENT CAUSE (B) <u>Generalized arteriosclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>54</u> to <u>May</u> , 19 <u>55</u> that I last saw the deceased alive on <u>May 4</u> , 19 <u>55</u> and that death occurred at <u>2 P.</u> M, from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
ADDRESS		M. D. <u>Wm. A. Rodgers</u> <u>May 7, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>Burial</u>		<u>5-11-55</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Sacred Heart of Mary German Hill Rd. Md.</u>		<u>John J. Hudson & Livewood</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR ADDRESS	
<u>5-9-55</u>		<u>John J. Hudson & Livewood</u>	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04423

4440

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Baltimore Co.</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Baltimore</i>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Rural Pikesville</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Rural Pikesville</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>10</i>				STREET ADDRESS (If rural give location) <i>204 Subbrook Lane, Pikesville</i>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: (Type or Print) <i>JAMES FRED OFFUTT</i>				DATE OF DEATH: <i>MAY 18 1955</i>			
5. SEX: <i>MALE</i>	6. COLOR OR RACE: <i>WHITE</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>MARRIED</i>	8. DATE OF BIRTH: <i>MAY 28, 1875</i>	9. AGE last birthday: <i>79</i> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Farmer</i>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <i>Baltimore Co., Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>		
13. FATHER'S NAME: <i>James Worthington Offutt</i>				14. MOTHER'S MAIDEN NAME: <i>Elizabeth Francis Cockey</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <i>No</i> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <i>Edward Jones Mason</i>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Uremia</i>							<i>2 weeks</i>
ANTECEDENT CAUSE (B) <i>Chronic Nephritis</i>							<i>few years</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>Arteriosclerosis, generalized</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Pneumonia, left lung</i>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>May 17, 1955</i> to <i>May 19, 1955</i> , that I last saw the deceased alive on <i>May 17, 1955</i> , and that death occurred at <i>12:10</i> M, from the causes and on the date stated above.							
SIGNATURE <i>Louis Salzman</i>		ADDRESS <i>M. D. 1413 Reisterstown Rd Pikesville</i>		DATE SIGNED <i>5/19/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	DATE THEREOF <i>May 21, 1955</i>	NAME OF CEMETERY OR CREMATORY <i>Druid Ridge Cemetery</i>		LOCATION (City, town or county) <i>Pikesville</i>		(State) <i>Maryland</i>	
DATE REC'D BY LOCAL REGISTRAR <i>5/20/1955</i>	REGISTRAR'S SIGNATURE <i>Harold A. Jewell</i>		24. FUNERAL DIRECTOR <i>Frank H. Howell</i>		ADDRESS <i>Pikesville</i>		

BUREAU V. S.

MAY 24 1955

RECEIVED

4441

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>Balt</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE</u> (15)			
X TOWN <u>FORT HOWARD</u>		6 HRS. 25 MIN.		STREET ADDRESS (If rural give location) <u>8514 MOUNT VERNON AVENUE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: (Type or Print) <u>ROBERT Winfield OLER</u>				OF DEATH: <u>MAY 17 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>MALE</u>	<u>WHITE</u>	<u>SINGLE</u>	<u>7/29/89</u>	<u>65</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>PAINTER</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>BALTIMORE, MARYLAND</u>	
13. FATHER'S NAME: <u>JOSH P. OLER</u>				14. MOTHER'S MAIDEN NAME: <u>MARTHA SMITH</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>YES WW I</u>				16. SOCIAL SECURITY NO. <u>217-05-1274</u>		17. INFORMANT & ADDRESS: <u>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>420.1</u>						<u>10 HRS.</u>	
IMMEDIATE CAUSE (A) <u>CORONARY THROMBOSIS, ACUTE</u>							
ANTECEDENT CAUSE (S) DUE TO <u>HYPERTENSIVE ARTERIOSCLEROTIC CARDIO*</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO <u>VXX VASCULAR DISEASE</u>						<u>UNKNOWN</u>	
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>VA M.</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>9:10 PM 3:35 AM</u>			
22. I hereby certify that I attended the deceased from <u>MAY 16, 1955</u> , to <u>MAY 17, 1955</u> and that death occurred at <u>3:35 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>F. S. Dickey</u>				ADDRESS <u>VAH, Fort Howard, Maryland</u>			
DATE SIGNED <u>May 20, 1955</u>				DATE SIGNED <u>5-17-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 20, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-18-55</u>		REGISTRAR'S SIGNATURE <u>aw fed...</u>		24. FUNERAL DIRECTOR ADDRESS <u>Loring Evers Funeral Home 5005 Park Heights Ave., Baltimore, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CONFIDENTIAL - (S)

1-1-68

PATIENT INFORMATION		PHYSICIAN INFORMATION		HISTORY OF PRESENT ILLNESS	
NAME	AGE	NAME	ADDRESS	DATE	TIME
JOHN DOE	45	DR. J. SMITH	123 MAIN ST.	1-1-68	10:00 AM
PATIENT'S HISTORY		PHYSICIAN'S HISTORY		LABORATORY DATA	
On 1-1-68, patient presented with a 2-week history of persistent cough, sputum production, and weight loss. No hemoptysis noted. Patient denies chest pain, dyspnea, or fever.		Patient has no significant past medical history. No recent travel to endemic areas. No contact with individuals having similar symptoms.		Chest X-ray: Mildly enlarged cardiac silhouette, no pulmonary infiltrates. Sputum: Negative for acid-fast bacilli. Tuberculin skin test: Negative.	
PHYSICIAN'S ASSESSMENT		PHYSICIAN'S PLAN		FOLLOW-UP	
Probable diagnosis: Tuberculosis. Recommend treatment with isoniazid, rifampin, pyrazinamide, and ethambutol. Monitor for side effects.		Prescribe 4-month course of therapy. Schedule follow-up in 4 weeks.		Return to clinic for re-evaluation and sputum studies.	

4442

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Northbrook</u>		TOWN <u>Northbrook</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>7729 Eastdale Road</u>		<u>7729 Eastdale Road</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>MARY ALICE OLIFF</u>		OF DEATH: <u>May 18, 19 55</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>female</u>	<u>white</u>	<u>Widowed</u>	<u>Sept. 3, 1873</u>
9. AGE last birthday		10. CITIZEN OF WHAT COUNTRY?	
<u>81</u> yrs.		<u>U. S. A.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
<u>housewife</u>		<u>at home</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Virginia</u>		<u>U. S. A.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Richard Scates</u>		<u>--</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
<u>--</u>		<u>---</u>	
17. INFORMANT & ADDRESS:			
<u>Edith Campbell, 7729 Eastdale Road</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		<u>6 days-</u>	
IMMEDIATE CAUSE (A)		<u>Cerebral Hemorrhage</u>	
ANTECEDENT CAUSE (S)		<u>Hypertension</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>0</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>April, 1966</u> , to <u>May 18, 1966</u> , that I last saw the deceased alive on <u>May 17, 1966</u> , and that death occurred at <u>4:30 A.M.</u> from the causes and on the date stated above.			
SIGNATURE		ADDRESS	
<u>David Schneider</u>		<u>M. D. 1101 N. Wilson Ave</u>	
DATE SIGNED			
<u>5-18-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>burial</u>		<u>5/21/55</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Oak Lawn Cemetery</u>		<u>Baltimore County, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
<u>5-19-55</u>		<u>A. W. Hedgcock</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>Wm. Book, Inc.</u>		<u>1217 St. Paul Street</u>	

MARGIN RESERVED FOR BINDING

1

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4443

CERTIFICATE OF DEATH

04426

Reg. Dist. No. 45

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		MARYLAND		STATE W.Va.,		COUNTY Greenbrier	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN White Marsh		2 wks.,		TOWN Otto		85X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Oscar		(Middle)		(Last) Oliver		(Month) May, (Day) 11, (Year) 1955	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
male	white	married	Oct. 15, 1894	60 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Farmer		Owner,		North Carolina		U.S.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Unknown				Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
yes		W.N. I		406-12-1932			
				Mrs. Bessie Oliver, White Marsh, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
151X IMMEDIATE CAUSE (A) CARCINOMATOSIS						10 MOS.	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE						18+ MOS	
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 11 MAY, 1955 , to 11 MAY, 1955 , that I last saw the deceased alive on 11 MAY, 1955 , and that death occurred at 9⁰⁰ P.M. from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
Maurin G. Epstein				12 May 1955			
ADDRESS (Street, city, town, state)							
M.D. 12 Yahde St. Edgewood, Md.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Removal		May, 12, 1955		Wallace & Wallace, F.H.		Lewisburg, Greenbrier, W.Va.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 5/20/55		Edith Hurley		Howard K. McComas & Son, Abingdon, Md.		Howard K. McComas Jr.	

CERTIFICATE OF DEATH

4443

Reg. Dist. No. 1

1. FULL NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. RACE

5. AGE

6. DATE OF DEATH

7. TIME OF DEATH

8. PLACE OF DEATH

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SEX

12. RACE

13. DATE OF DEATH

14. TIME OF DEATH

15. FULL NAME OF DECEASED

16. SEX

17. RACE

18. CAUSE OF DEATH

19. MANNER OF DEATH

20. DATE OF DEATH

21. TIME OF DEATH

22. FULL NAME OF DECEASED

23. SEX

24. CAUSE OF DEATH

25. MANNER OF DEATH

BUREAU V. S.

MAY 25 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4444

CERTIFICATE OF DEATH

Reg. Dist. No.

04427

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore, Md. (6)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7928 E 32nd St</u>				STREET ADDRESS (If rural give location) <u>7928 E 32nd St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Irene Louise O'Neill</u>				<u>May 23 1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH: <u>Jan 3 1892</u>	9. AGE last birthday: <u>63</u> yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS.: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Ill.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Elaine Le Bour</u>				14. MOTHER'S MAIDEN NAME:			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>9</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Wm Kennedy - Whinnell 79</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
171X IMMEDIATE CAUSE		(A) <u>Carcinoma of the Cervix</u>				18 months	
ANTECEDENT CAUSE (S):		DUE TO					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B)					
		(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April</u> , 19 <u>53</u> , to <u>May</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 21</u> , 19 <u>55</u> , and that death occurred at <u>5:20A</u> M. from the causes and on the date stated above.							
SIGNATURE <u>James R. M... M.D.</u>		ADDRESS <u>M. D. 8019 Philadelphia Rd.</u>		DATE SIGNED <u>May 23, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>3-23-55 - PA</u>				<u>Arlington Cemetery</u>		<u>Drexel Hill Pa</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>3-23-55 - PA</u>		<u>Wm Corry Inc</u>		<u>1217 St Paul St</u>			

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04428

4445

CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		X	
X TOWN <u>Freeland.</u>		<u>1 yr.</u>		<u>Freeland</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>00 Ruhl Rd.</u>				<u>Ruhl Rd.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Fount. C. Owens.</u>				<u>May 24, 1955.</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	10. UNDER 1 YEAR	11. UNDER 24 HRS.	
<u>M</u>	<u>W.</u>	<u>Married</u>	<u>Sept. 12, 1893</u>	<u>61</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Carpenter</u>		<u>Carpentering</u>		<u>Smith Co., Va.</u>		<u>U. S. A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Sherwood Owens.</u>				<u>Josie Johnson.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>9</u>		<u>403-01-5513</u>		<u>Mrs. Stanley Unpacker - Freeland, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>162X Bronchogenic Carcinoma with metastasis</u>						<u>Mar. 1954</u>	
ANTECEDENT CAUSE (S) DUE TO						<u>to</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO						<u>May 24, 1955</u>	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Portal cirrhosis</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
<u>April 6, 1954</u>		<u>Bronchogenic Carcinoma rt. lung.</u>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>Mar. 1955</u>		<u>Carcinoma of left kidney.</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-29, 1954</u> , to <u>5-24, 1955</u> , that I last saw the deceased alive on <u>5-24, 1955</u> , and that death occurred at <u>7:25 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Richard F. Robinson</u>				ADDRESS <u>New Freedom Pa.</u>		DATE SIGNED <u>5-25-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 27, 1955</u>		<u>Mt. Zion Cemetery</u>		<u>Freeland, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR		ADDRESS	
<u>5/26/55</u>		<u>Charles F. Freeland</u>		<u>Isaac Portenstein</u>		<u>New Freedom Pa.</u>	

BUREAU V. S.

1955

RECEIVED

04429

MARYLAND

STATE DEPARTMENT OF HEALTH

4446

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Glyndon		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Glyndon	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 2 Chatsworth Ave.		STREET ADDRESS (If rural, give location) 2 Chatsworth Ave.	
3. NAME OF DECEASED (Type or Print) Walter W. Penn		4. DATE OF DEATH May 8, 1955	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH May 19, 1932
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Heating business		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 72 yrs. If under 1 year: Months Days Hours Min.
11. FATHER'S NAME George W. Penn		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. MOTHER'S MAIDEN NAME Emma V. McCaulley		14. INFORMANT AND ADDRESS Mrs. J. Alden Smith, Glyndon, Md.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No. 165-10-1783	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.2 Immediate cause (a) Coronary Artery Disease		2 yrs 4 mo.
Antecedent cause(s) (b) Angina Pectoris		2 yrs 4 mo.
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) None.		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION None	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) None.	PLACE (Home, farm, factory, street, OF office bldg., etc.) None.	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY None. m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? None.
22. I hereby certify that I attended the deceased from 9-25 , 1947, to 5-8 , 1955, that I last saw the deceased alive on 5-7 , 1955, and that death occurred at 1 P.m., from the causes and on the date stated above.		
SIGNATURE D.D. Epline (Degree or title)		ADDRESS M.D. Reisterstown, Md.
DATE SIGNED 5-10-55		
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE May 11, 1955	NAME OF CEMETERY OR CREMATORY All-Saints
LOCATION (City, town, or county) Reisterstown, Md.		(State)
DATE REC'D BY LOCAL REG. 5-11-55	REGISTRAR'S SIGNATURE Mary B. Eline	24. FUNERAL DIRECTOR J.F. Eline & Sons, Reisterstown, Md.

MARGIN RESERVED FOR BINDING

BUREAU V. S.

MAY 13 1915

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

47

1. PLACE OF DEATH: <i>Baltimore County</i>		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Craddock's Nursing Home</i>	STATE <i>Md.</i> COUNTY	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Baltimore</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Halethorpe Md.</i>	LENGTH OF STAY (in this place) <i>1 yr. 2 mo.</i>	STREET ADDRESS (If rural give location) <i>1029 Stricker Street</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>1900 N. East ave.</i>			
3. NAME OF DECEASED: (First) <i>William</i> (Middle) (Last) <i>Pickett</i>		4. DATE (Month) (Day) (Year) OF DEATH: <i>May 3 1955</i>	
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>Negro</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED: <i>unknown</i>	8. DATE OF BIRTH: <i>47 yrs.</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>unknown</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>unknown</i>	11. BIRTHPLACE (State or foreign country): <i>unknown</i>
13. FATHER'S NAME: <i>unknown</i>		14. MOTHER'S MAIDEN NAME: <i>unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS:	

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Hemiplegia + Epilepsy</i>			
ANTECEDENT CAUSE (S) DUE TO (B) <i>Cardiac Disease</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <i>0</i>	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>May 16, 1954</i> to <i>May 3, 1955</i> , that I last saw the deceased alive on <i>3-3</i> , 1955, and that death occurred at <i>1:30 PM</i> , from the causes and on the date stated above.			
SIGNATURE <i>Dr. J. M. Kieffer</i>		ADDRESS <i>Elkridge Md</i>	DATE SIGNED <i>May 3 1955</i>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Stored</i>	DATE THEREOF <i>June 2, 1955</i>	NAME OF CEMETERY OR CREMATORY <i>Wm. J. Maryland Med. Sch., Balto. 1, Maryland</i>	LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REGISTRAR <i>June 24, 1955</i>	REGISTRAR'S SIGNATURE <i>Geo. J. M. Kieffer</i>	24. FUNERAL DIRECTOR <i>The Anatomy Board of Maryland</i>	ADDRESS <i>pu: Dr. M. Christie</i>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 27 1955

RECEIVED

4447

Reg. Dist. No. 32

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES GOVERNMENT OF BRITAIN

OFFICE OF THE ATTORNEY GENERAL

DEPARTMENT OF JUSTICE

WASHINGTON, D. C.

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BUREAU V. S.

MAY 20 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

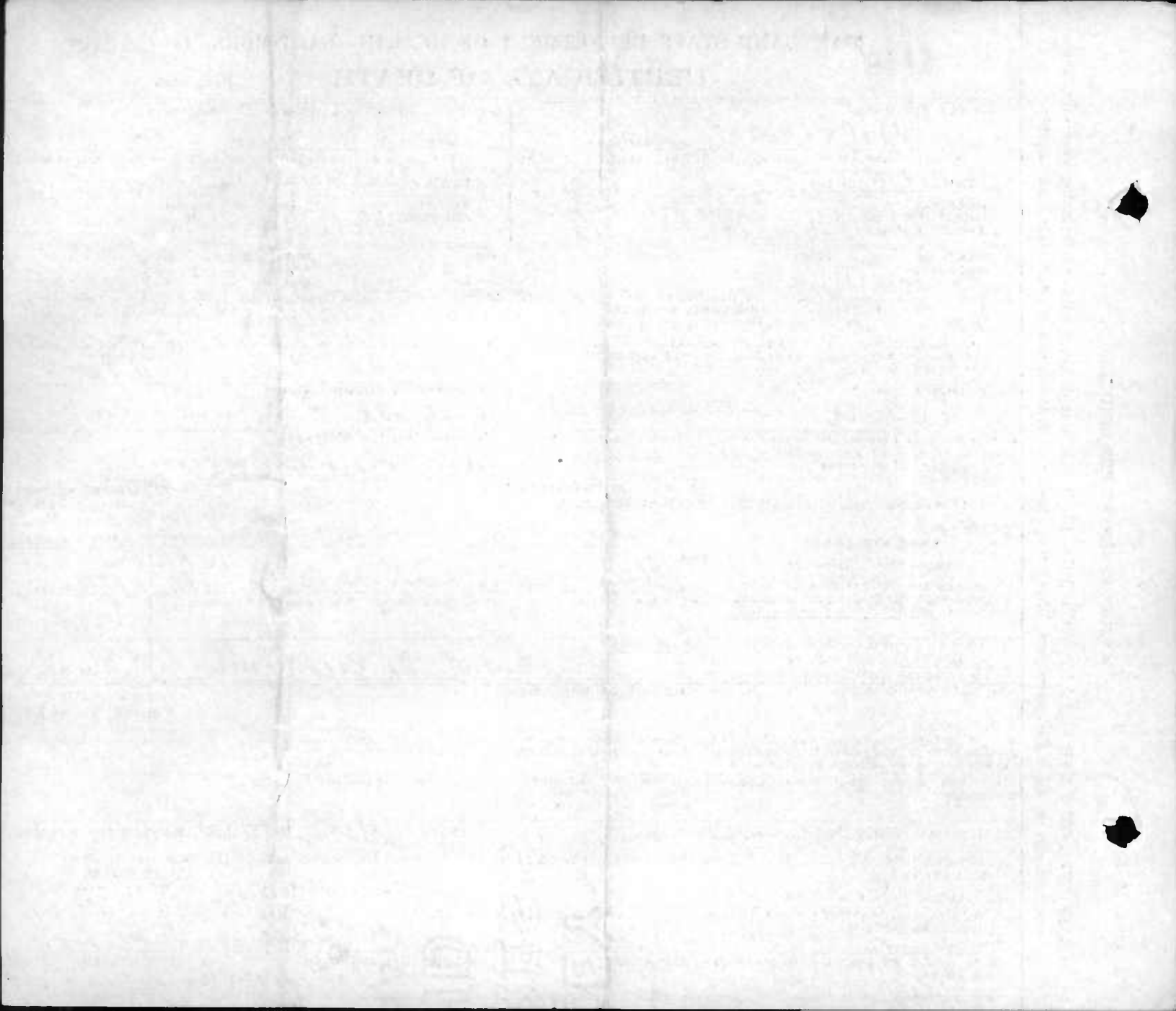
4449

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04432

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u> Md. </u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>52 Catonsville 28</u>		LENGTH OF STAY (in this place) <u>496 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore, 23 3rd-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove St. Hospital Catonsville 28 Md.</u>				STREET ADDRESS (If rural give location) <u>109 N. Carey St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Hazel PRELLER</u>				OF DEATH: <u>5 - 30 - 1955</u>			
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>w.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>wid.</u>	8. DATE OF BIRTH: <u>4.18.1894</u>	9. AGE last birthday <u>61</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Mln.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Arthur (last-unknown)</u>				14. MOTHER'S MAIDEN NAME: <u>Certurde (last-unknown)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>unk.</u>		16. SOCIAL SECURITY NO. <u>unk.</u>		17. INFORMANT & ADDRESS: <u>This Hospital's Records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>443X</u>		(A) <u>Cardiovascular disease with hypertension</u>				<u>unknown</u>	
ANTECEDENT CAUSE (S)		DUE TO					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>(904.7)</u>		(B) <u>Chronic brain syndrome associated with cerebral arteriosclerosis</u>				<u>unknown</u>	
		DUE TO					
		(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Fracture of the left femur</u>						<u>8 months</u>	
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/19</u> , 1954, to <u>5/30</u> , 1955, that I last saw the deceased alive on <u>5/30</u> , 1955, and that death occurred at <u>1:40 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Bruno Radauskas</u>				ADDRESS <u>M.D. Spring Grove St. Hospital</u>		DATE SIGNED <u>5/30/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/2/55</u>		NAME OF CEMETERY OR CREMATORY <u>Haley Cross</u>		LOCATION (City, town, or county) (State) <u>Ritchie Highway</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6/4/55</u>		REGISTRAR'S SIGNATURE <u>A.W. Hedrick</u>		24. FUNERAL DIRECTOR <u>J. J. Carey & Sons</u>		ADDRESS <u>1318 Light</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

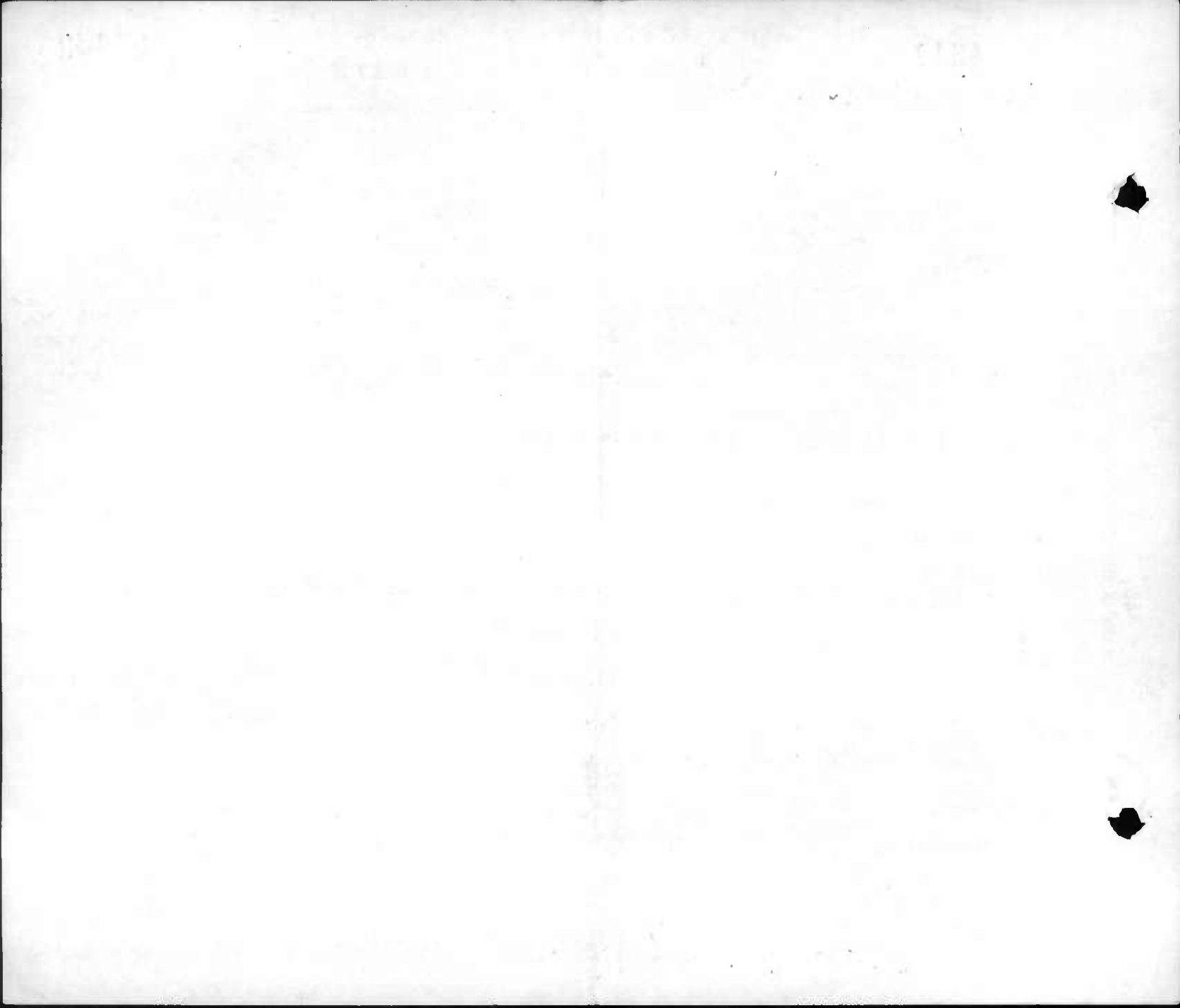
04433

CERTIFICATE OF DEATH

Reg. Dist. No.

Items 13, 14, Film G182 6-7-55 et

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY — <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY —	
CITY (If outside corporate limits, write OR and give nearest town) <u>Relig</u>		LENGTH OF STAY (in this place) <u>4 days</u>		CITY (If outside corporate limits, write OR and give nearest town) <u>Baltimore</u>		3V01-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Relig Hill Hospital</u>				STREET ADDRESS (If rural give location) <u>205 E Preston</u>			
3. NAME OF DECEASED: (First) <u>GILBERT</u> (Middle) <u>R.</u> (Last) <u>PRODDFOOT</u>				4. DATE OF DEATH: (Month) <u>May</u> (Day) <u>25</u> (Year) <u>1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>1/21/1871</u>	
9. AGE last birthday: <u>84</u> yrs.		10. MONTHS <u>12</u> DAYS <u>25</u> HOURS <u>19</u> MIN.		11. BIRTHPLACE (State or foreign country): <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): <u>Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Teacher</u>			
13. FATHER'S NAME: <u>"No record"</u>				14. MOTHER'S MAIDEN NAME: <u>"No record"</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u>				16. SOCIAL SECURITY No.: <u>9</u>			
17. INFORMANT & ADDRESS:							
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
420.0 Immediate cause (a) <u>Pulmonary edema</u>						1 hour	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u>						Several years.	
(c) <u>Bilateral vaginal lacerations</u>						?	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>—</u>						19b. MAJOR FINDINGS OF OPERATION: <u>—</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/21</u> , 1955, to <u>5/25</u> , 1955, that I last saw the deceased alive on <u>5/29</u> 1955, and that death occurred at <u>2:20 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>Leo P. Ruby M.D.</u>				ADDRESS <u>Relig 27, Md.</u>		DATE SIGNED <u>5/25/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5/27/55</u>		<u>Louisa Park</u>		<u>Balto. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>5-26-55</u>		<u>Dr. W. H. H. H. H.</u>		<u>Wm. Cook Inc. 1217 St. Paul St.</u>			



4448

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) Essey
 TOWN Essey
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 104 N. Stuart Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE md COUNTY Balto.
 CITY (If outside corporate limits, write RURAL and give nearest town) Essey
 TOWN Essey
 STREET ADDRESS (If rural, give location) 104 N. Stuart Ave.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

4. DATE (Month) (Day) (Year)

DECEASED:

FrankPuchniowski(PETERSON)

OF DEATH:

5-2019 55

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH:

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

MaleWhiteMarriedJan. 27 - 189560 yrs. 3 24

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

Electrician OperatorMerritt TrustMaryland

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

William PuchniowskiAnnie Puchniowski

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

NoMrs. Mary Puchniowski (Wife)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

INTERVAL BETWEEN ONSET AND DEATH

163X

Immediate cause

(a)

DUE TO

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

DUE TO

(c)

Pulmonary edemaPulmonary carcinoma11 min10 min

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Not while work ☐ at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb, 1955, to 5/20, 1955, that I last saw the deceasedalive on 5/20, 1955, and that death occurred at 11:30 P. m., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial5-24-55Oak LawnEastern Blvd.md.

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

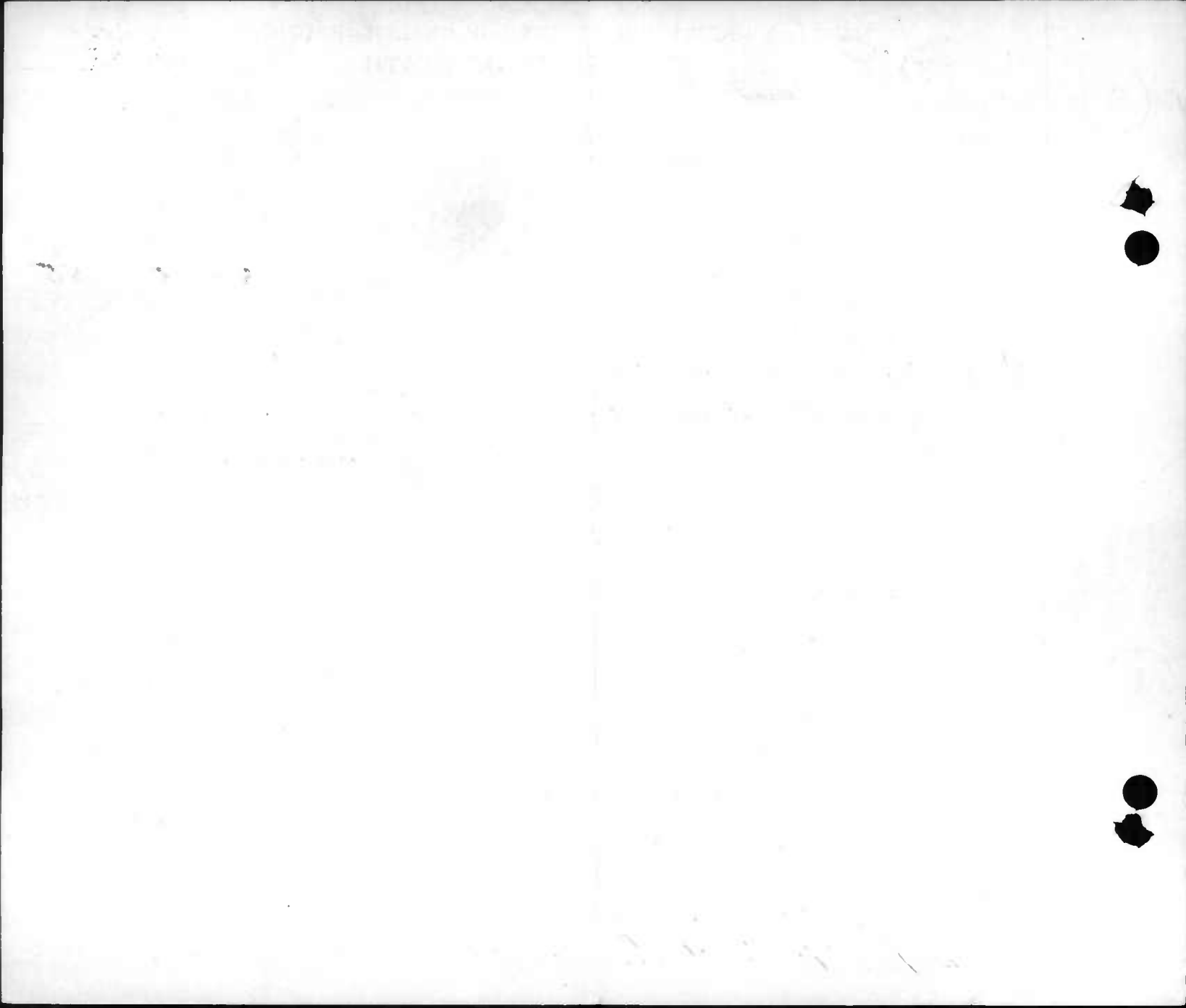
24. FUNERAL DIRECTOR

ADDRESS

5/23/55H. H. HedrichJohn S. ConnellyEssey md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



M.

4337

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04434
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 41

I. PLACE OF DEATH:

COUNTY

Balto

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)
TOWN Dundalk 22LENGTH OF STAY
(in this place)
12

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Md

COUNTY

BALTO

CITY (If outside corporate limits write RURAL and give nearest town)
OR
TOWN 5211 German Hill Rd. xHOSPITAL OR
INSTITUTION OR
STREET ADDRESS

5211 German Hill Rd -

STREET
ADDRESS

Gray Manor -

(If rural, give location)

3. NAME OF
DECEASED:
(Type or Print)

(First)

(Middle)

(Last)

John

Neloni

Redcay

4. DATE
OF
DEATH

May 22

1955

5. SEX:

Male

6. COLOR OR
RACE:

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify):

Married

8. DATE OF BIRTH:

Nov 27-1918

9. AGE last birthday:

36 yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of
work done during most of work life,
if any, and under what conditions)

Mechanics

10b. KIND OF BUSINESS OR
INDUSTRY:

Pa. R.R.

11. BIRTHPLACE (State or foreign country):

Pa.

12. CITIZEN OF WHAT
COUNTRY:

U.S.A.

13. FATHER'S NAME:

James Leon Redcay

14. MOTHER'S MAIDEN NAME:

Blanche Reinbold

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)

YES WW II

16. SOCIAL SECURITY No.:

212-26-0913

17. INFORMANT & ADDRESS:

Thm. Redcay (brother)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a) DUE TO

Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause
stating underlying cause last

(b) DUE TO

(c)

Coronary occlusion -
Coronary diseaseINTERVAL BETWEEN
ONSET AND DEATHSubacute
5-10 min
per yearII. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS
PRIMARY ☐ or CONTRIBUTING ☐
CAUSE OF DEATH.21b. PLACE (Home, farm, factory,
OF
street, office bldg., etc.,
INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour)

May 5 22 55 7A

21e. INJURY OCCURRED

While at work ☒ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

M. D.

M. D.

CHIEF MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DATE SIGNED

23. BURIAL, CREMATION,
REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town or county)

(State)

DATE REC'D BY LOCAL
REG.

May 22 1955

REGISTRAR'S SIGNATURE

William M. Kelly

24. FUNERAL DIRECTOR

W. Brock Bradley, Dundalk, Md

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1955

1955

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RECEIVED

MAY 24 1955

BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04435

4450

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CATONSVILLE</u> LENGTH OF STAY (in this place) <u>8 YRS.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CATONSVILLE</u> 52	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>617 HILLTOP ROAD</u>		STREET ADDRESS (If rural, give location) <u>617 HILLTOP ROAD</u> 1	
3. NAME OF DECEASED (First) <u>SUSIE</u> (Middle) <u>ELIZABETH</u> (Last) <u>REPP.</u>	4. DATE OF DEATH (Month) <u>MAY</u> (Day) <u>12</u> (Year) <u>1955</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>10-4-65</u>
9. AGE last birthday <u>89</u> yrs.		10. If under 1 year 11. If under 24 hrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Seippel</u>		14. MOTHER'S MAIDEN NAME <u>SUSAN Schlotthauer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>HELEN Schrodetzki, 617 Hilltop Rd.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Hypertensive A.A.C.V.D.</u>			
Antecedent cause(s) (b) _____			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>4/2</u> , 19 <u>55</u> , to <u>5/12</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/12</u> , 19 <u>55</u> , and that death occurred at <u>6:30 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>John E. Fealy M.D.</u>		ADDRESS <u>Baltimore, Md.</u> DATE SIGNED <u>5/13/55</u>	
23. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE <u>5-16-55</u>	NAME OF CEMETERY OR CREMATORY <u>London Park</u>	LOCATION (City, town, or county) <u>BALTIMORE Md.</u> (State)
DATE REC'D BY LOCAL REG. <u>5/14/55</u>	REGISTRAR'S SIGNATURE <u>V.E. Harry</u>	24. FUNERAL DIRECTOR <u>George L. Schwab</u> ADDRESS <u>2101 Frederick Ave. - BALTO., Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 16 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4451
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04436
 Reg. Dist. 45

No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Ind</u>	COUNTY <u>—</u>
CITY (If outside corporate limits, write RURAL OR and the nearest town) TOWN <u>Middle River</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Baltimore 29.</u>	3601.4
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>St. Martin's</u>		STREET ADDRESS (If rural, give location) <u>3714 Claremont Rd.</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>Melvin</u>	(Middle) <u>S.</u>	(Last) <u>Rice</u>	(Month) <u>May</u> (Day) <u>9</u> (Year) <u>1955</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH: <u>Nov 11, 1902</u>
9. AGE last birthday: <u>52</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Port Washington N.Y.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of work life): <u>Operating Engr.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>?</u>		14. MOTHER'S MAIDEN NAME: <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY No.: <u>M.W. 1+2</u>	
17. INFORMANT & ADDRESS: <u>Vera V. Rice 3714 Claremont Rd.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary occlusion</u>			<u>2.00 min.</u>
DUE TO			
Antecedent cause(s) (b) <u>giving rise to the above cause</u>			
DUE TO stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: <u>May 9 1955</u>		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) <u>Sept - May 9 1955 3:30 P.M.</u>	21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>M. L. Carmine M.D.</u>		DATE SIGNED <u>5/11/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>5/11/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Balto National</u>		LOCATION (City, town, or county) (State) <u>Baltimore Ind</u>	
DATE REC'D BY LOCAL REG. <u>5-10-55</u>		REGISTRAR'S SIGNATURE <u>W. Hedrick</u>	
FUNERAL DIRECTOR <u>Paul C. Schenck</u>		ADDRESS <u>3645-17 Chestnut Ave.</u>	

115
Capt Newen.

Plat #2

04437

MARYLAND

4452

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH-
COUNTY

Baltimore

MARYLAND

2. USUAL RESIDENCE (HOME) OF DECEASED-
STATE

Md.

COUNTY Balto.

CITY (If outside corporate limits, write RURAL and OR give nearest town)

52 TOWN Catonsville

LENGTH OF STAY
(In this place)

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Catonsville 52

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

3 21 Lambeth Rd

STREET
ADDRESS(If rural, give location)
321 Lambeth Rd3. NAME OF
DECEASED
(Type or Print)

George L. Richter

(Last)

4. DATE
OF
DEATH(Month) (Day) (Year)
May 5/55

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)

Single

8. DATE OF BIRTH

Jan. 7, 1882

9. AGE last birthday

73 yrs.

If under 1 year

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Installation

10b. KIND OF BUSINESS OR
INDUSTRY

C.&P. Telephone

Balto. Md.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT
COUNTRY?

13. FATHER'S NAME

John O. Richter

Co.

14. MOTHER'S MAIDEN NAME

Elizabeth Thesing

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If year, give war and dates of
service)

yes

16. SOCIAL SECURITY No.

WM 1-212 05 0591

17. INFORMANT AND ADDRESS

Miss Dessie V. Richter, 321 Lambeth RD

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN
ONSET AND DEATH420.1
Immediate cause

(a)

Coronary Thrombosis

1 hr.

Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last

(b)

Ch. Nephritis & Ch. Valvular heart

died 10 yrs

(c)

Arterio Sclerosis

10 yrs

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,
OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURYINJURY OCCURRED
While at Not While
Work ☐ At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-14, 1950, to 5-5-55, 19, that I last saw the deceased

alive on 5-3-55, 19, and that death occurred at 3:30 A.M., from the causes and on the date stated above.

SIGNATURE

Geo. C. Wells

(Degree or title)

ADDRESS

4100 Edmondson Ave 28 Balto. Md. 5/5/55

DATE SIGNED

23. BURIAL, CREMATION
REMOVAL (Specify)

Burial

DATE

May 7/55

NAME OF CEMETERY OR CREMATORY

Lorraine Pl.

LOCATION (City, town or county)

Woodlawn, Balto. Md.

(State)

DATE REC'D BY LOCAL
REG.

5-6-55

REGISTRAR'S SIGNATURE

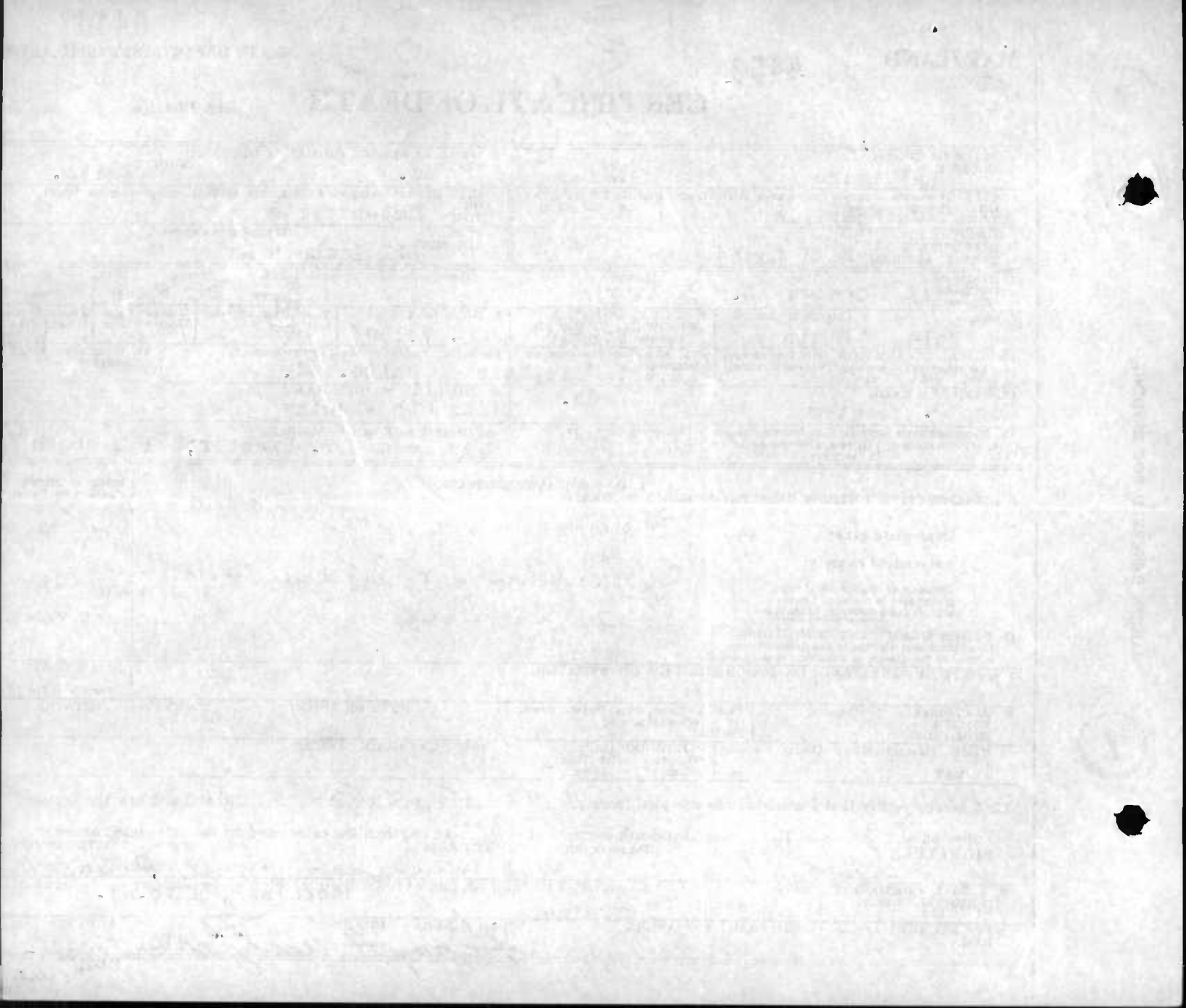
A. W. Herring

24. FUNERAL DIRECTOR

Harry H. Wintzler 4101

ADDRESS

Edmondson Ave



4453

MARYLAND STATE DEPARTMENT OF HEALTH

04438

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 43

1. PLACE OF DEATH COUNTY <u>Balto</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Raspebury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Raspebury</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>206 Elinor Ave</u>		STREET ADDRESS (If rural, give location) <u>206 Elinor Ave</u>	
3. NAME OF DECEASED (First) <u>James</u> (Middle) <u>B</u> (Last) <u>Riley</u>		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>25</u> (Year) <u>1954</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Sept 5, 1921</u>
9. AGE last birthday <u>33</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Medel worker</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford Co md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>W Frank Riley</u>		14. MOTHER'S MAIDEN NAME <u>Rhoda M Chenworth</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes World War II</u>		16. SOCIAL SECURITY NO. <u>Ridervvood</u>	
17. INFORMATION AND ADDRESS <u>Mrs Rhoda Chenworth Riley md</u>		18. MEDICAL CERTIFICATION	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause

(a)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.PLACE (Home, farm, factory, street, or office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

May 28 '55 Mrs. M. T. Reifender Lassalle Funeral Home 7401 Belair Rd

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY; WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 3 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

04439

4454

2411 N. Charles Street, Baltimore

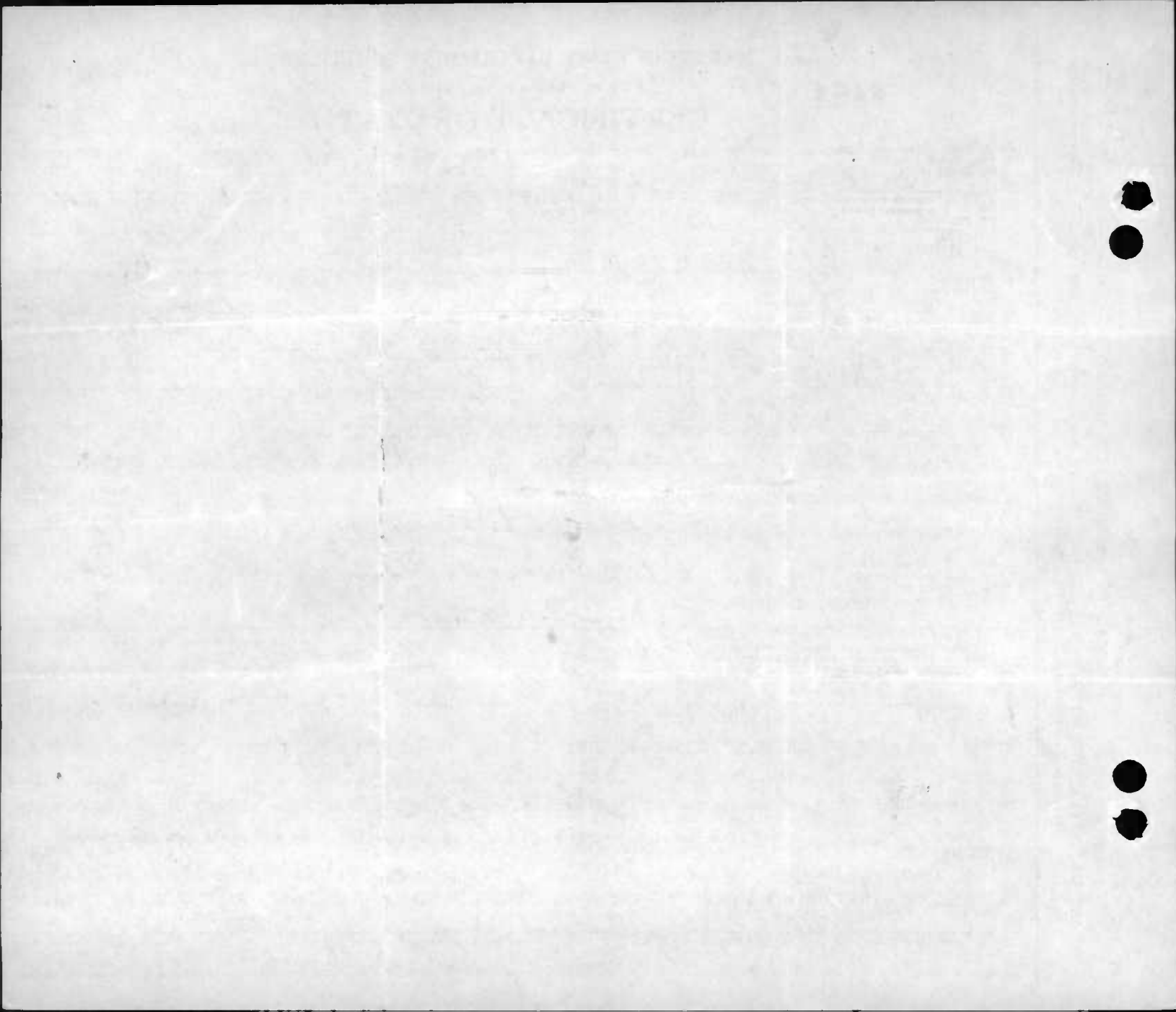
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Baltimore</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Balt.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN</u>		LENGTH OF STAY (in this place) <u>24</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7517 Lange Avenue</u>				STREET ADDRESS (If rural, give location) <u>7517 Lange Avenue</u>	
3. NAME OF DECEASED (Type or Print) <u>Charles</u> (First) <u>-</u> (Middle) <u>Raebe</u> (Last)		4. DATE OF DEATH <u>May 22</u> (Month) (Day) (Year) <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 26, 1874</u>	9. AGE last birthday <u>80</u> yrs.	If under 1 year Months Days Hours Min. <u>80</u> <u>0</u> <u>0</u> <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labour - Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>G. A. Braun</u>		11. BIRTHPLACE (State or foreign country) <u>Balt. Md.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		13. FATHER'S NAME <u>Theodore Raebe</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>9</u>		16. SOCIAL SECURITY NO. <u>212-01-67799</u>		17. INFORMANT AND ADDRESS <u>Raymond C. Raebe - 7517 Lange Ave.</u>	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					INTERVAL BETWEEN ONSET AND DEATH
331X Immediate cause (a) <u>Cerebral Hemorrhage</u>					<u>4 hours</u>
Antecedent cause(s) (b) <u>Hypertension - Brady Cardia</u>					<u>1 year</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Arterio-Sclerosis</u>					<u>2</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypertrophied Prostate</u>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY		(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Nov 10, 1954</u> , to <u>May 22, 1955</u> , that I last saw the deceased alive on <u>May 22, 1955</u> , and that death occurred at <u>11:50 a.m.</u> , from the causes and on the date stated above.					
SIGNATURE <u>Monis G. Jurek M.D.</u>		(Degree or title)		ADDRESS <u>1010 North St Rt. 24, Bethesda Md</u>	
DATE SIGNED <u>5/23/55</u>					
23. BURIAL CREMATION REMOVAL (Specify) <u>None</u>		DATE THEREOF <u>5/25/55</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore Cem.</u>	
LOCATION (City, town, or county) <u>Baltimore, Md.</u>		(State) <u>Md.</u>			
DATE REC'D BY LOCAL REG. <u>5-25-55</u>		REGISTRAR'S SIGNATURE <u>R. W. Hedlund</u>		FEDERAL DIRECTOR <u>John C. Miller Inc. - 2431 E. Oliver St.</u>	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING



4455

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04440

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) Catonsville				CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS House of The Pines Rusting Ave				STREET ADDRESS (If rural, give location) 6104 Pimlico Road			
3. NAME OF DECEASED (Type or Print)		(First) Lucy		(Middle) Jane		(Last) Rickerd	
5. SEX Female		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced		4. DATE OF DEATH (Month) May (Day) 30 (Year) 1955	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 3-25-1875		9. AGE last birthday 80 yrs. 2 mos 5 days	
11. BIRTHPLACE (State or foreign country) Olive Township, Michigan				12. CITIZEN OF WHAT COUNTRY USA			
13. FATHER'S NAME William Webb				14. MOTHER'S MAIDEN NAME Lucy M. Carpenter			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Y				16. SOCIAL SECURITY No. (If yes, give war or dates of service)		17. INFORMANT Mrs Dorothy Newman, 6104 Pimlico Rd.	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause 447x Hypertension - Essential (a)							
Antecedent cause(s) Arteriosclerosis (b)							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)				PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 5/20 , 19 50 , to 5/30 , 19 55 , that I last saw the deceased alive on 5/30 , 19 55 , and that death occurred at 10:15 m., from the causes and on the date stated above.							
SIGNATURE Daniel J. Schwartz MD				ADDRESS 2320 Eutaw Place		DATE SIGNED 5/31/55	
23. BURIAL, CREMATION REMOVAL (Specify) Removal		DATE THEREOF 6-2-55		NAME OF CEMETERY OR CREMATORY Crystal Cemetery		LOCATION (City, town, or county) (State) Michigan	
DATE REC'D BY LOCAL REG. 5-31-55		REGISTRAR'S SIGNATURE C. W. Hedrick		24. FUNERAL DIRECTOR David R. Martin		ADDRESS 1902 Eutaw Place	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4456

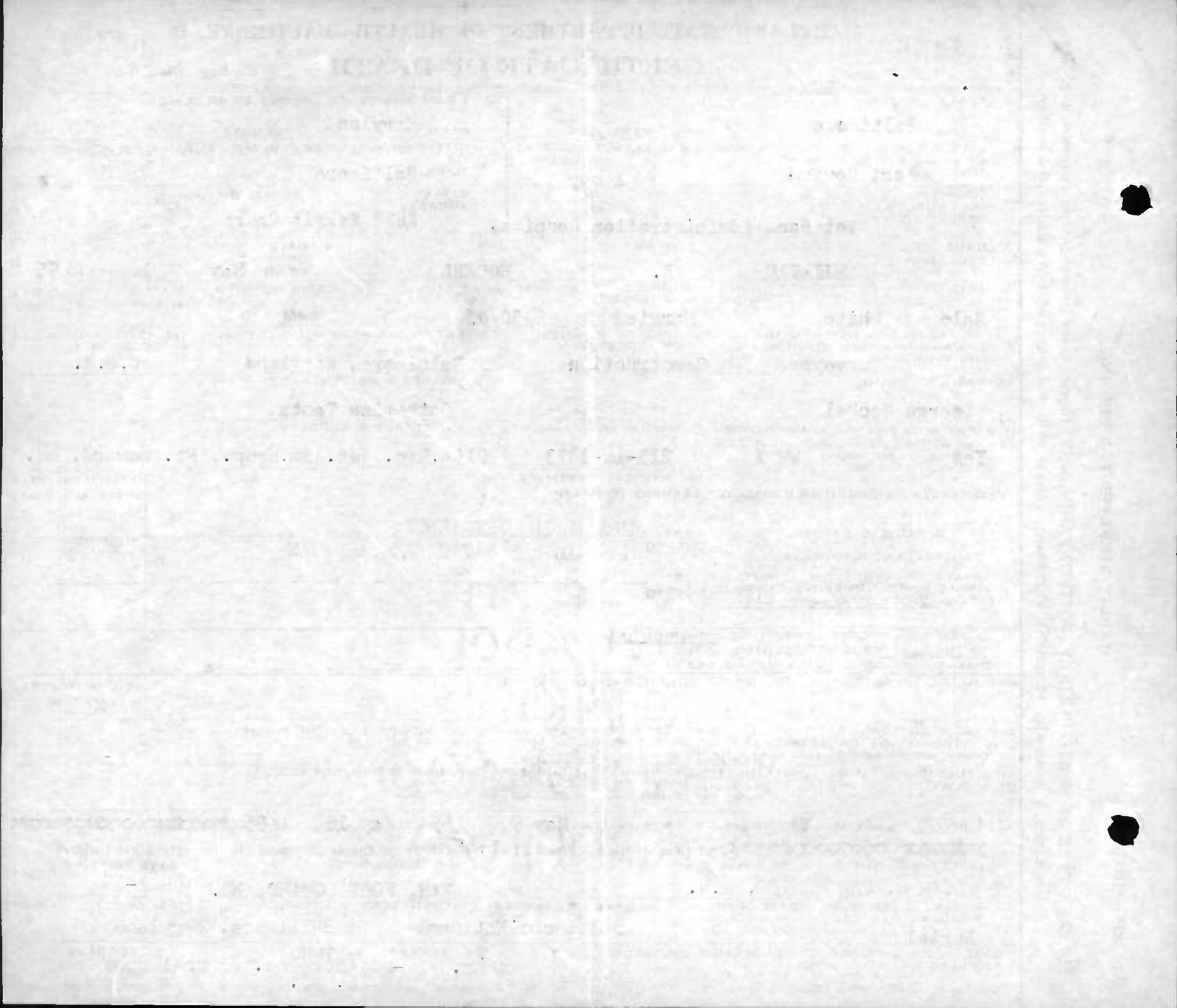
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04441

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN Fort Howard		1 day		TOWN Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
50 Veterans Administration Hospital				2427 Kermit Court			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year)			
(First) (Middle) (Last)				OF DEATH: May 10 19 55			
WILLIAM R. ROCKEL							
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
Male		White		Married		5/30/90	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Surveyor		Construction		Baltimore, Maryland		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
George Rockel				Catherine Tantz			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
Yes		(If Yes, give war or dates of service) WW I		213-14-2873			
				Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) MITRAL INSUFFICIENCY						UNKNOWN	
ANTECEDENT CAUSE (S) DUE TO CHRONIC RHEUMATIC ENDOCARDITIS						UNKNOWN	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (B)							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
2							
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 9 , 19 55 , to May 10 , 19 55 , and that death occurred at 6:45 PM , from the causes and on the date stated above.							
SIGNATURE				ADDRESS			
WILLIAM B. VANDEGRIFT, M.D.				VAH, FORT HOWARD, MD.			
DATE SIGNED 5-12-55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		5/13/55		Baltimore National		Baltimore, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
5-13-55		W. H. Hedgcock		Wm. Cook-Blight, Inc. Funeral Home		Baltimore 14, Md.	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

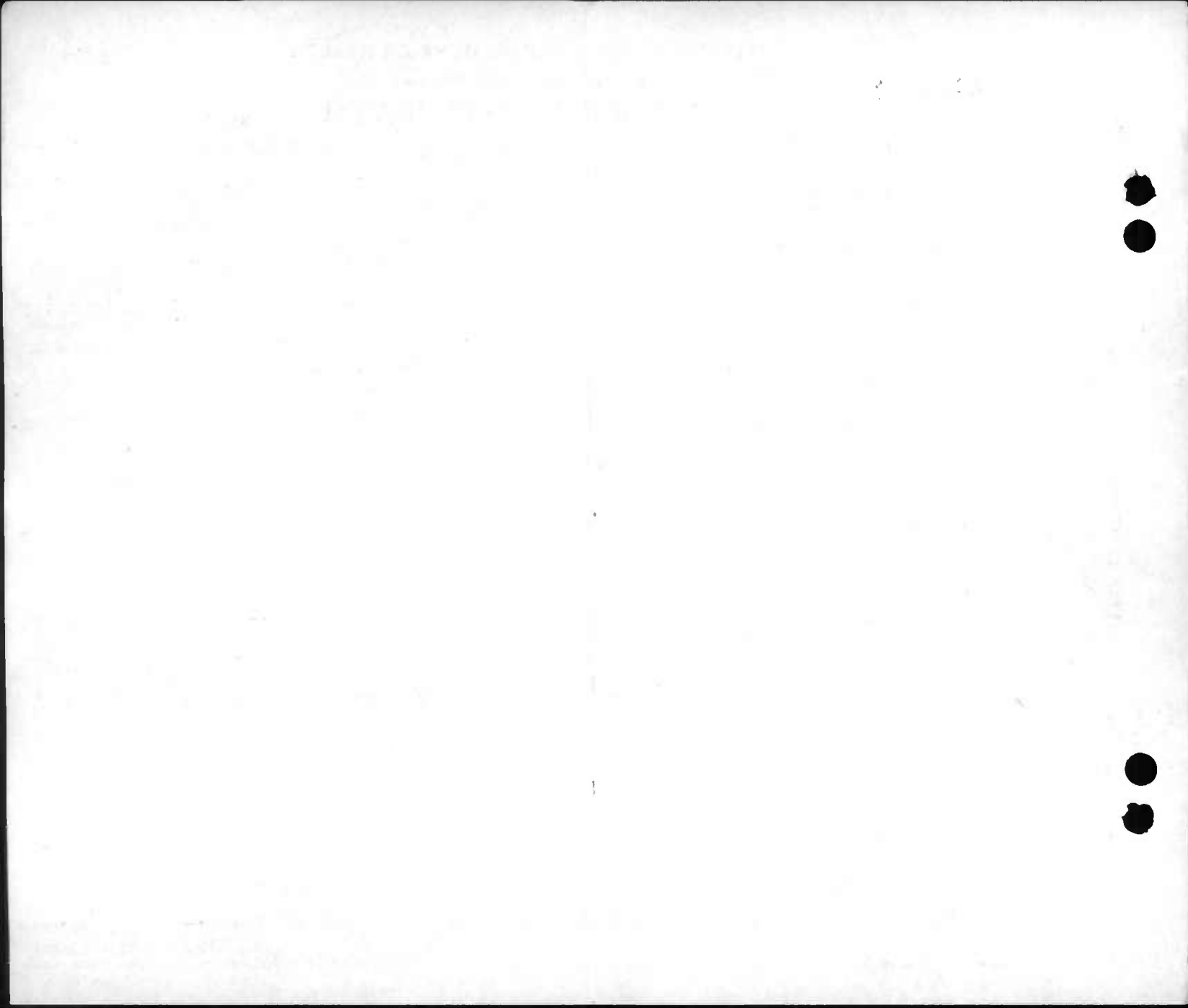
2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

04443

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md. COUNTY Balto.			
CITY (If outside corporate limits, write RURAL and give nearest town) Riderwood				CITY (If outside corporate limits, write RURAL and give nearest town) Riderwood			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1901 Old Court Rd				STREET ADDRESS (If rural, give location) 1901 Old Court Road			
3. NAME OF DECEASED (Type or Print)		(First) Ruth		(Middle) Elizabeth		(Last) Roller	
5. SEX Female		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single		4. DATE OF DEATH May 5, 1955	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH Sept. 23, 1938		9. AGE last birthday 16 yrs.	
13. FATHER'S NAME Vernon Roy Roller				12. CITIZEN OF WHAT COUNTRY U.S.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT Vernon R. Roller 1901 Old Court Rd. Riderwood Md.	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
197X Immediate cause (a) Liposarcoma of pelvis						6 mos	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION 2/21/55		19b. MAJOR FINDINGS OF OPERATION Suppurative Liposarcoma				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4/29 , 19 55 , to 5/5 , 19 55 , that I last saw the deceased alive on 5/4 , 19 55 , and that death occurred at 2:45 p.m. , from the causes and on the date stated above.							
SIGNATURE Renneth A. Staers				DATE THEREOF May 8, 1955		NAME OF CEMETERY OR CREMATORY Falls Road Methodist	
DATE REC'D BY LOCAL REG. 5-6-55				REGISTRAR'S SIGNATURE John O. Mitchell		LOCATION (City, town, or county) (State) Baltimore, Co. Md.	
24. FUNERAL DIRECTOR John O. Mitchell & Sons Inc.				ADDRESS 1900 Eutaw Place			



4458

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04442

CERTIFICATE OF DEATH

Reg. Dist. No. 30

Items 13, 14 Film 181 5-18-55 et

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Balt. Cty</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>935 Homestead St.</u>	
3. NAME OF DECEASED (First) <u>Annie</u>	(Middle) <u>N</u>	(Last) <u>Rowland</u>	4. DATE OF DEATH (Month) <u>May</u> (Day) <u>13</u> (Year) <u>1955</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb. 11, 1972</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Packer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u>	9. AGE last birthday <u>83</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>-- Neiss</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>1000A</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Margaret Obst 935 Homestead St</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
331X Immediate cause (a) <u>Cerebrovascular accident</u>			<u>Minutes</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Arteriosclerosis, generalized</u>			<u>Unknown</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED White at Work <input type="checkbox"/> Not White At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>7-26</u> , 19 <u>55</u> , to <u>5-13</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-13</u> , 19 <u>55</u> and that death occurred at <u>10:00A</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Stephen Lee Hapness MD</u>		ADDRESS <u>Catonsville 28 Rd</u>	
DATE SIGNED <u>5-19-55</u>			
23. BURIAL, CREMATION REBURY (Specify) <u>Burial</u>	DATE THEREOF <u>May 16, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	LOCATION (City, town, or county) <u>Baltimore Maryland</u>
24. FUNERAL DIRECTOR REG. <u>5-14-55</u>	REGISTERAR'S SIGNATURE <u>RW</u>	ADDRESS <u>Raymond J. Curran 713 Homestead St</u>	
Balt., 10 Md.			

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4459

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04444

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTO.</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>EDGEEMERE (19)</u>		<u>9 YRS</u>		TOWN <u>EDGEEMERE (19)</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>P.O. BOX #29</u>				STREET ADDRESS (If rural give location) <u>PO. BOX #29-</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>ALEXANDER JOHN ROZWADOWSKI</u>				<u>5-8-1955</u>			
5. SEX: <u>m.</u>		6. COLOR OR RACE: <u>W.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>		8. DATE OF BIRTH: <u>5 MARCH 1896</u>	
				9. AGE last birthday: <u>59</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, (specify if retired): <u>WATER CARETAKER</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>STEEL MFR.</u>		11. BIRTHPLACE (State or foreign country): <u>RUSSIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>RUSSIA</u>							
13. FATHER'S NAME: <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME: <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY No.: <u>213-07-8733</u>		17. INFORMANT & ADDRESS: <u>ANNA R. ROZWADOWSKI - SAME</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset and Death	
204.1 Immediate cause (a) <u>Myocardial Infarction</u>						<u>2 days</u>	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Chronic Myelogenous Leukemia</u>						<u>6 mos</u>	
(c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE		HOMICIDE		INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 14, 1955</u> , to <u>May 8, 1955</u> , that I last saw the deceased alive on <u>May 8, 1955</u> , and that death occurred at <u>11:00 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>James H. Means</u>				DATE SIGNED <u>5/9/55</u>			
ADDRESS <u>520 D St. Balto 19 Md.</u>							
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5-11-55</u>		<u>Green Mount</u>		<u>Balto. Co. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 10-55</u>				FUNERAL DIRECTOR <u>Walter Burke Bradley, Parkville, Md.</u>			
LOCAL REGISTRAR'S SIGNATURE <u>L. Harbor</u>							

BUREAU V. S.

MAY 12 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4460

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04445

Item 9, Film G183, 6/30/55

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTO		MARYLAND		STATE Md.		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) 52 CATONSVILLE		LENGTH OF STAY (in this place) 7 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) 3601.4 Balto. City			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 14 Spring Grove State Hospital				STREET ADDRESS (If rural give location) 1078 W. Belington Ave			
3. NAME OF DECEASED: (First) (Middle) (Last) EMMA M. SAMUELS				4. DATE (Month) (Day) (Year) OF DEATH: 5-19-1955			
5. SEX: F	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: 6-1881	9. AGE last birthday 73	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of occupation during most of working life.) Refr. Saleswoman		10B. KIND OF BUSINESS OR INDUSTRY: Department Store Maryland		11. BIRTHPLACE (State or foreign country): USA		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: Thomas Bibson				14. MOTHER'S MAIDEN NAME: Margaret Ann Thomas			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO.: Unknown		17. INFORMANT & ADDRESS: SON 1719 N. UNION AVE.			
18. MEDICAL CERTIFICATION				CRATERED ONSET AND DATE			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) 430.0 Atherosclerotic heart disease				years			
ANTECEDENT CAUSE (S) (B) Generalized Atherosclerosis				years			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Senility and Debility				years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6-22-1948 to 5-19-1955 , that I last saw the deceased alive on 5-19-1955 , and that death occurred at 7:45 PM from the causes and on the date stated above.							
SIGNATURE S. Waehler				DATE SIGNED 5-19-55			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORIAL LOCATION (City, County, State)			
Burial		May 21 1955		Louisa Park Cem. Baltimore Md.			
DATE REC'D BY LOCAL REGISTRAR 5-20-55		REGISTRAR'S SIGNATURE A. W. Hedgcock		FUNERAL DIRECTOR Phyllis Sammons		ADDRESS 4501 W. 14th Ave	

15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 841. 842. 843. 844. 845. 846. 847. 848. 849. 850.

115

4461

CERTIFICATE OF DEATH

Reg. Dist. No. 44

| | | | |
|--|--------------------------------|--|--|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY BALTIMORE | MARYLAND | STATE MARYLAND | COUNTY |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) | |
| X TOWN PORT HOWARD | 77 days | TOWN BALTIMORE | 3401.4 |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL | | STREET ADDRESS (If rural give location) 407 PATAPSCO AVENUE | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | 4. DATE (Month) (Day) (Year) | |
| FREDERICK J. SCHREIBER | | OF DEATH: MAY 8 19 55 | |
| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH: |
| MALE | WHITE | WIDOWED | 6-30-78 |
| 9. AGE last birthday | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 76 yrs. | | 76 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): | | 10B. KIND OF BUSINESS OR INDUSTRY: | |
| LABORER | | BRICK YARD | |
| 11. BIRTHPLACE (State or foreign country): | | 12. CITIZEN OF WHAT COUNTRY? | |
| BALTIMORE, MARYLAND | | U.S.A. | |
| 13. FATHER'S NAME: | | 14. MOTHER'S MAIDEN NAME: | |
| FERDINAND SCHREIBER | | BARBARA BECK | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 2 YES | | UNKNOWN | |
| 17. INFORMANT & ADDRESS: | | 18. MEDICAL CERTIFICATION | |
| CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MD. | | I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | |
| IMMEDIATE CAUSE | | (A) INTESTINAL OBSTRUCTION, LOWER ILLUM | INTERVAL BETWEEN ONSET AND DEATH 24 HOURS |
| ANTECEDENT CAUSE (S): | | (B) ADHESIVE BAND | UNKNOWN |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | 1. ARTERIOSCLEROTIC HEART DISEASE | |
| | | 2. DIABETES MELLITUS | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | |
| 5-7-55 | | INTESTINAL OBSTRUCTION DUE TO ADHESIVE BAND | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, street, office bldg., etc.) | |
| | | 21C. WHERE DID (City or town) (County) (State) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from Feb. 20, 19 55 , to May 8, 19 55 , and that death occurred at 10:30 AM from the causes and on the date stated above. | | | |
| SIGNATURE Irving Freeman | | ADDRESS VAH, Fort Howard, Md. | |
| DATE SIGNED 5-8-55 | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | |
| Burial | | May 11, 1955 | |
| NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| Baltimore National Cemetery | | Baltimore, Maryland | |
| DATE REC'D BY LOCAL REGISTRAR | | REGISTRAR'S SIGNATURE | |
| 5-9-55 | | J. G. CONNELLY | |
| | | ADDRESS 418 Eastern Ave., Baltimore, Maryland | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FEDERAL BUREAU OF INVESTIGATION

100-100000

TO THE DIRECTOR, FEDERAL BUREAU OF INVESTIGATION
FROM THE SAC, NEW YORK (100-100000)
SUBJECT: [Illegible]
RE: [Illegible]
[The following text is mirrored and largely illegible due to bleed-through from the reverse side of the page. It appears to be a memorandum or report detailing an investigation.]

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4462

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2, Film 181 5-16-55 et

CERTIFICATE OF DEATH

Reg. Dist. No.

044470

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY Balto. | MARYLAND | STATE Md. | COUNTY Balto. |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) 52 Catonsville | LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Catonsville Baltimore | 301.4 |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 Catonsville Convalescent Home Ingleside & Edmondson Aves. | STREET ADDRESS Catonsville Nursing Home Ingleside and Edmondson Ave 2836 N. North Ave. | | |
| 3. NAME OF DECEASED: (First) SUSAN (Middle) PRUDENCE (Last) SCHROEDER | | 4. DATE (Month) (Day) (Year) OF DEATH: May 8, 19 55 | |
| 5. SEX: female | 6. COLOR OR RACE: white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single | 8. DATE OF BIRTH: Oct. 4, 1869 |
| 9. AGE last birthday 85 yrs. | | IF UNDER 1 YEAR | IF UNDER 24 HRS. |
| | | Months | Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none | | 10B. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): Maryland |
| 13. FATHER'S NAME: Richard Ford Schroeder | | 14. MOTHER'S MAIDEN NAME: Anne Elizabeth Wood | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT & ADDRESS: Rev. J. H. Braunlein-405 Normandy Ave. | | | |
| 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | |
| IMMEDIATE CAUSE 420.1 | | | |
| ANTECEDENT CAUSE (S): | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | |
| (A) Coronary Thrombosis | | Ind days. | |
| (B) Arterio sclerotic Cardio Vascular Disease | | 10 years | |
| (C) Senility | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19A. DATE OF OPERATION: 0 No operation | | 19B. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from Dec 31, 1950 , to May 8, 1955 , that I last saw the deceased alive on May 8, 1955 , and that death occurred at 11:30 P M, from the causes and on the date stated above. | | | |
| SIGNATURE Joshua H. Armacost | | ADDRESS 6419 Windsor Mill Rd Baltimore | |
| DATE SIGNED 5-10-55 | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 5/12/55 | NAME OF CEMETERY OR CREMATORY Lorraine Park Cem. | LOCATION (City, town, or county) (State) Woodlawn, Md. |
| DATE REC'D BY LOCAL REGISTRAR 5-10-55 | REGISTRAR'S SIGNATURE Wm. J. Hedrick | 24. FUNERAL DIRECTOR Wm. J. Hedrick & Sons | ADDRESS Baltimore Md. |

STATE OF NEW YORK
IN SENATE

REPORT OF THE
COMMISSIONER OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 18, 1890
ALBANY: J. B. LIPPINCOTT & CO. PRINTERS.
1891.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4463

CERTIFICATE OF DEATH

Reg. Dist. No. 30

04448

| | | | | | | | |
|---|--------------------------------|--|------------------------------------|--|--|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Baltimore</u> | | MARYLAND | | STATE <u>Maryland</u> COUNTY <u>Harford</u> | | | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>52 Catonsville</u> | | LENGTH OF STAY (in this place) <u>2 mos. 5 days</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Fallston</u> <u>12X-2</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove State Hospital</u> | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | 4. DATE (Month) (Day) (Year) | | OF DEATH: <u>May 16,</u> 19 <u>55</u> | | | |
| (Type or Print) <u>Mattie A. Sexton</u> | | | | | | | |
| 5. SEX: <u>Female</u> | 6. COLOR OR RACE: <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>widowed</u> | 8. DATE OF BIRTH: <u>12-2-1896</u> | 9. AGE last birthday <u>58</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Factory work</u> | | 10B. KIND OF BUSINESS OR INDUSTRY: | | 11. BIRTHPLACE (State or foreign country): <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME: <u>Unknown</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | | 17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hospital</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE (A) <u>Terminal bilateral pneumonia</u> | | | | | | <u>3 days</u> | |
| ANTECEDENT CAUSE (S) (B) <u>Inanition and dehydration</u> | | | | | | <u>Weeks</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Acute senile brain disease</u> | | | | | | <u>2 months</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: <u>2</u> | | 19B. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) INJURY OCCUR? (County) (State) | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>3-11-</u> 19 <u>55</u> to <u>5-16-</u> 19 <u>55</u> , and that death occurred at <u>10 A M.</u> from the causes and on the date stated above. | | | | | | | |
| alive on <u>5-16-</u> 19 <u>55</u> | | DATE SIGNED <u>5-17-55</u> | | | | | |
| SIGNATURE <u>S. Wachler</u> | | ADDRESS <u>Spring Grove State Hospital</u> | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>May 19 1955</u> | | NAME OF CEMETERY OR CREMATORY <u>Friendship Methodist</u> | | LOCATION (City or town, or county) (State) <u>Fallston, Md. Hfd</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>5/17/55</u> | | REGISTRAR'S SIGNATURE <u>V.E. Harvey</u> | | 24. FUNERAL DIRECTOR <u>W.H. Archer</u> | | ADDRESS <u>Benson Rd</u> | |

BUREAU V. S.

MAY 18 1955

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 41

4338

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>Baltimore</u> | MARYLAND | STATE <u>Maryland</u> | COUNTY <u>Balto.</u> |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> | LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>259 Colgate Ave.</u> | | STREET ADDRESS (If rural give location) <u>259 Colgate Ave.</u> | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | 4. DATE OF DEATH: (Month) (Day) (Year) | |
| <u>HARRY S. SHEALEY</u> | | <u>May 13 1955</u> | |
| 5. SEX: <u>Male</u> | 6. COLOR OR RACE: <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u> | 8. DATE OF BIRTH: <u>March 27, 1872</u> |
| 9. AGE last birthday: <u>83</u> yrs. | | 10. BIRTHPLACE (State or foreign country): <u>Maryland</u> | |
| 11. BIRTHPLACE (State or foreign country): <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME: <u>Henry Shealey</u> | | 14. MOTHER'S MAIDEN NAME: <u>Mary A. Shock</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No.</u> | | 16. SOCIAL SECURITY No.: <u>-</u> | |
| 17. INFORMANT & ADDRESS: <u>Mrs. Lucille Kellner Apt. A 1, Dunleer Apts.</u> | | | |
| 18. MEDICAL CERTIFICATION | | | |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | Interval Between Onset And Death | |
| <u>152X</u> | | <u>6 months</u> | |
| Immediate cause (a) <u>Carcinomatosis</u> | | | |
| Antecedent causes (s) (b) <u>Carcinoma Small intestines</u> | | <u>2 yrs</u> | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) | | | |
| 11. OTHER SIGNIFICANT CONDITIONS | | | |
| Conditions contributing to the death but not related to the disease or condition causing death. | | | |
| 19a. DATE OF OPERATION: <u>May 13, 1955</u> | | 19b. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? <u>Yes</u> <input type="checkbox"/> <u>No</u> <input checked="" type="checkbox"/> | | | |
| 21. ACCIDENT (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) (STATE) |
| <u>SUICIDE</u> | <u>INJURY</u> | | |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | HOW DID INJURY OCCUR? | |
| | | | |
| 22. I hereby certify that I attended the deceased from <u>Jan 1944</u> to <u>May 13, 1955</u> , that I last saw the deceased alive on <u>May 10, 1955</u> , and that death occurred at <u>9 AM</u> , from the causes and on the date stated above. | | | |
| SIGNATURE <u>Wand A. Andrew M.D.</u> | | DATE SIGNED <u>5/14/55</u> | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) | | DATE THEREOF | NAME OF CEMETERY OR CREMATORY |
| <u>Burial</u> | | <u>May 16, 1955</u> | <u>Oak Lawn</u> |
| LOCATION (City, town, or county) (State) | | 24. FUNERAL DIRECTOR | |
| <u>Colgate Md.</u> | | <u>Ullrich Funeral Home 2112 Dundalk Ave.</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>May 15-1955</u> | | REGISTRAR'S SIGNATURE <u>William M. Kelly</u> | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 16 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4464

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04450

CERTIFICATE OF DEATH

Reg. Dist. No. 37

| | | | | | | | |
|--|--------------------------------|--|--|---|-----------------------------|---|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Baltimore</u> | | MARYLAND | | STATE <u>Md.</u> | | COUNTY <u>Baltimore</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| X TOWN <u>Sparks (Rural)</u> | | <u>3 yrs</u> | | TOWN <u>Sparks (Rural)</u> X | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>York Rd</u> | | | | STREET ADDRESS (If rural give location) <u>York Rd.</u> | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | | | 4. DATE (Month) (Day) (Year) | | | |
| <u>Howard Eugene Shelley</u> | | | | DEATH: <u>May 2 1955</u> | | | |
| 5. SEX: <u>male</u> | 6. COLOR OR RACE: <u>white</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>married</u> | 8. DATE OF BIRTH: <u>Oct. 17, 1884</u> | 9. AGE last birthday <u>70</u> yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>farmer</u> | | 10B. KIND OF BUSINESS OR INDUSTRY: <u>farm</u> | | 11. BIRTHPLACE (State or foreign country): <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY: <u>U.S.A</u> | |
| 13. FATHER'S NAME: <u>Joshua Shelley</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Rebecca Hackett</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. _____ | | 17. INFORMANT & ADDRESS: <u>Mrs Alice F. Shelley, Sparks, Md.</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE (A) <u>Coronary occlusion</u> | | | | | | | <u>3 hrs.</u> |
| ANTECEDENT CAUSE (B) | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: <u>0</u> | | | | 19B. MAJOR FINDINGS OF OPERATION | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) | | INJURY OCCUR? | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>May 2</u> , 19 <u>55</u> , to <u>May 2</u> , 19 <u>55</u> ; that I last saw the deceased alive on <u>May 2</u> , 19 <u>55</u> , and that death occurred at <u>5 P</u> M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>A. M. France</u> | | | | M. D. <u>Sanford, Md.</u> | | DATE SIGNED <u>5/3/55</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>5-5-55</u> | | <u>Mt. Zion</u> | | <u>Freeland, Md.</u> | |
| DATE REC'D BY LOCAL REGISTRAR | | REGISTRAR'S SIGNATURE | | 24. FUNERAL DIRECTOR | | ADDRESS | |
| <u>4 May 1955</u> | | <u>Ann Unisue MacRae</u> | | <u>Brooks Funeral Service, Sparks, Md.</u> | | | |

BUREAU V. S.

MAY 5 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04451

4465

CERTIFICATE OF DEATH

Reg. Dis. No.

| | | | | | | | |
|---|-------------------|--|-------------------|---|-----------------|--|---|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY BALTIMORE | | MARYLAND | | STATE MARYLAND | | COUNTY | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| X TOWN FORT HOWARD | | 159 DAYS | | TOWN BALTIMORE 3401-4 | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL | | | | STREET ADDRESS (If rural give location) 201 S. ANN STREET | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | | | 4. DATE (Month) (Day) (Year) | | | |
| WALTER P SHERBA | | | | OF DEATH: MAY 2 1955 | | | |
| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: | 9. AGE last birthday | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| MALE | WHITE | SINGLE | 6/28/21 | 33 yrs | Months | Days | Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): | | 10B. KIND OF BUSINESS OR INDUSTRY: | | 11. BIRTHPLACE (State or foreign country): | | 12. CITIZEN OF WHAT COUNTRY? | |
| Store Work | | STORE | | BALTIMORE, MARYLAND | | U.S.A. | |
| 13. FATHER'S NAME: | | | | 14. MOTHER'S MAIDEN NAME: | | | |
| ALEXANDER SHERBA | | | | MARY LIPPS | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS: | | | |
| YES (If Yes, give war or dates of service) WW-II | | UNKNOWN | | CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MD. | | | |
| 18. MEDICAL CERTIFICATION | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| 2041 IMMEDIATE CAUSE (A) MYELOID LEUKEMIA, ACUTE | | | | | | | 2 MONTHS |
| ANTECEDENT CAUSE (S): DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO | | | | | | | |
| (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. AGNOGENIC MYELOID METAPLASIA | | | | | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | | | | | 20. AUTOPSY? |
| 1/11/55 | | SPLENECTOMY * AGNOGENIC MYELOID METAPLASIA | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) | | 21D. HOW DID INJURY OCCUR? | |
| | | | | | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from Nov. 24, 1954 to May 2, 1955 , and that death occurred at 2:00 P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE Francis G. Dickey, M.D. | | | | ADDRESS VAH, Fort Howard, Md. DATE SIGNED 5/2/55 | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| BURIAL | | May 5/55 | | HOLY ROSARY CEMETERY | | BALTIMORE, MARYLAND | |
| DATE REC'D BY LOCAL REGISTRAR | | REGISTRAR'S SIGNATURE | | 24. FUNERAL DIRECTOR | | ADDRESS | |
| 5/3/55 | | L | | FRED W. OZAZEWSKI FUNERAL HOME | | 1930 EASTERN AVE. BALTIMORE, Md. | |

STATE OF NEW YORK
IN SENATE
JANUARY 1, 1903.

REPORT OF THE

COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1902.

ALBANY:

JOHN W. BAKER, PRINTERS.

1903.

THE STATE OF NEW YORK.

IN SENATE.

JANUARY 1, 1903.

REPORT OF THE

COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1902.

ALBANY:

JOHN W. BAKER, PRINTERS.

1903.

THE STATE OF NEW YORK.

IN SENATE.

JANUARY 1, 1903.

REPORT OF THE

COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1902.

ALBANY:

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1903.

THE STATE OF NEW YORK.

IN SENATE.

JANUARY 1, 1903.

REPORT OF THE

COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1902.

ALBANY:

JOHN W. BAKER, PRINTERS.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4466

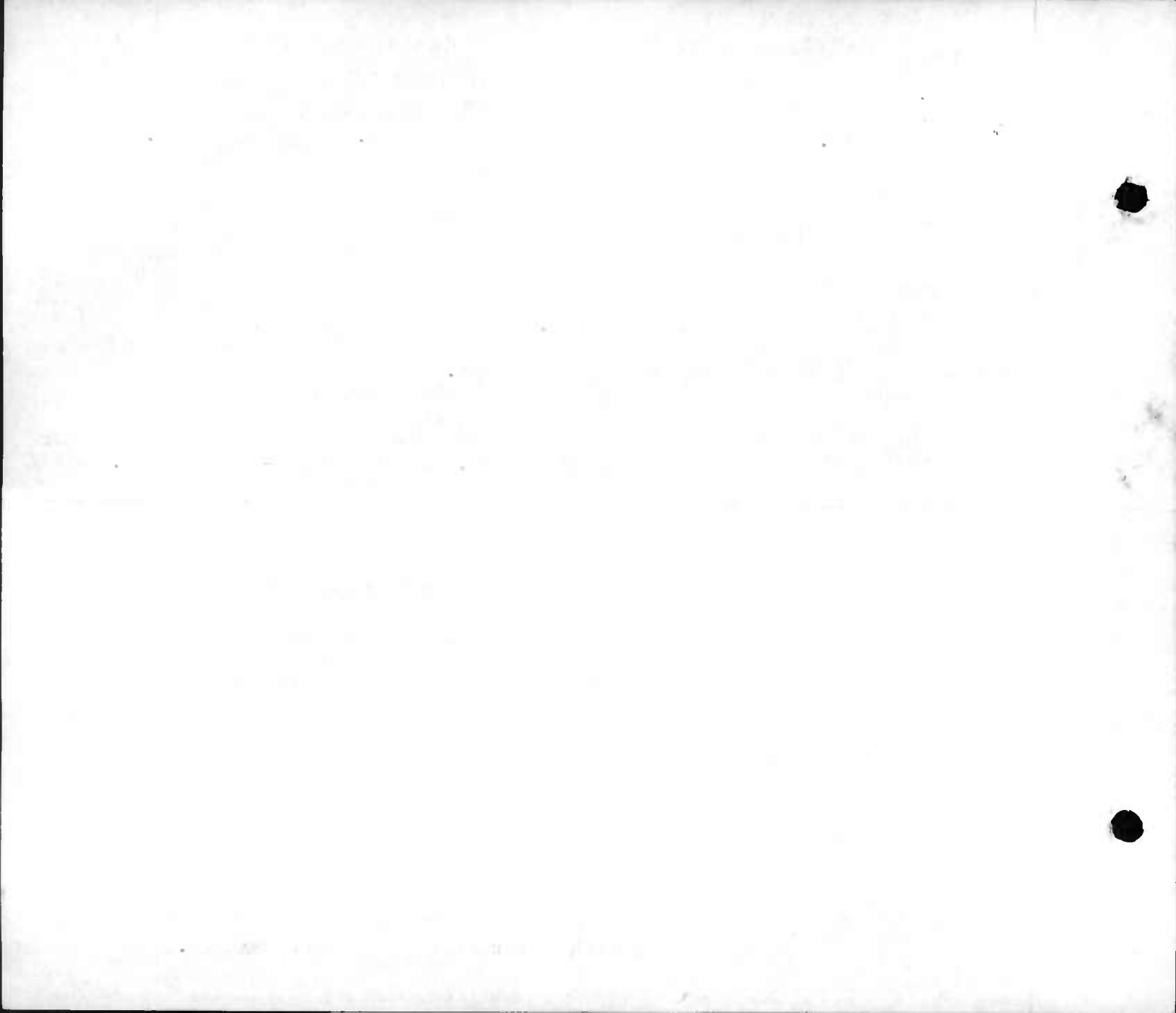
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04452

CERTIFICATE OF DEATH

Reg. Dist. No. 38

| | | | | | | | |
|--|--------------------------------|--|---|---|--|--|--------------------------------|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Balto.</u> | | MARYLAND | | STATE <u>Md.</u> | | COUNTY <u>Balto.</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town)
<u>Lutherville</u> | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town)
<u>Lutherville</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>College Manor</u> | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED: (First) <u>CORA</u> | | (Middle) | | (Last) <u>SHIELDS</u> | | 4. DATE (Month) (Day) (Year)
OF DEATH: <u>May</u> <u>18</u> <u>19</u> <u>55</u> | |
| 5. SEX: <u>female</u> | 6. COLOR OR RACE: <u>white</u> | 7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): <u>widowed</u> | 8. DATE OF BIRTH: <u>Jan. 10, 1865</u> | | 9. AGE last birthday <u>90</u> yrs. | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY: <u>at home</u> | | 11. BIRTHPLACE (State or foreign country): <u>Penna.</u> | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME: <u>John Lewis</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT & ADDRESS: <u>York</u>
<u>Mrs. Robert Clarkson-550 Park Ave., New /</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u> | | | | | | | |
| ANTECEDENT CAUSE (S) DUE TO (B) <u>Hypertensive Cardio-Vascular Disease</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: <u>0</u> | | | | 19B. MAJOR FINDINGS OF OPERATION | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) | | INJURY OCCUR? | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>March</u> 19 <u>55</u> , to <u>MAY</u> , 19 <u>55</u> that I last saw the deceased alive on <u>5/18/</u> , 19 <u>55</u> , and that death occurred at <u>1:40</u> PM, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>M. Quinn</u> | | ADDRESS <u>TIMONIUM</u> | | DATE SIGNED <u>5/19/55</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>5/20/55</u> | | NAME OF CEMETERY OR CREMATORY <u>Church of Redeemer</u> | | LOCATION (City, town, or county) (State) <u>Bryn Mawr, Pa.</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>5-20-55</u> | | REGISTRAR'S SIGNATURE <u>a w Hedgcock</u> | | FURNERAL DIRECTOR <u>Wm. F. Grohner & Sons</u> | | ADDRESS <u>Balt 17</u> | |



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4453
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04453
 Reg. Dist.

No. 45

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Baltimore County</u> | | MARYLAND | | STATE <u>Maryland</u> COUNTY <u>Baltimore</u> | | | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)
<u>Rural</u>
<u>U.S. 90 Highway</u> | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits write RURAL and give nearest town)
<u>Victory Villa</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural, give location)
<u>3 Kelly Road Baltimore 20</u> | | | |
| 3. NAME OF DECEASED: | | | | 4. DATE OF DEATH | | | |
| (First) <u>Hugh</u> | | (Middle) <u>D</u> | | (Last) <u>Shuffler</u> | | DATE OF DEATH <u>5 29 1953</u> | |
| 5. SEX: <u>M</u> | | 6. COLOR OR RACE: <u>White</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u> | | 8. DATE OF BIRTH: <u>Jan. 1, 1934</u> | |
| 9. AGE last birthday: <u>21</u> yrs. | | IF UNDER 1 YEAR: Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>unemployed</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY: | | 11. BIRTHPLACE (State or foreign country): <u>Mitchell Co. N. C.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME: <u>Carrick N. Shuffler</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Sally E. Garland</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
<u>No</u> | | | | 16. SOCIAL SECURITY No.: | | 17. INFORMANT & ADDRESS: <u>Mr. Carrick N. Shuffler, 3 Kelly Rd.</u> | |
| 18. MEDICAL CERTIFICATION | | | | | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | | | | | |
| Immediate cause (a) <u>Asphyxiation</u>
DUE TO | | | | | | | |
| Antecedent cause(s) (b) <u>Drowning</u>
Diseases or conditions, if any, giving rise to the above cause DUE TO | | | | | | | |
| stating underlying cause last (c) | | | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION: <u>0</u> | | | | 19b. MAJOR FINDING OF OPERATION: | | | |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Rural</u> | | 21c. (City or town) (County) (State)
<u>Quarryville Baltimore County Maryland</u> | | | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>5 29 55 PM</u> | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? <u>Drown while swimming</u> | | | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| SIGNATURE: <u>William Upovich</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>5-30-53</u>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
M. D. ASSISTANT MEDICAL EXAM. | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u> | | DATE THEREOF: <u>5-30-55</u> | | NAME OF CEMETERY OR CREMATORY: <u>Presbyterian Cemetery</u> | | LOCATION (City, town, or county) (State): <u>Buladean Co. N.C.</u> | |
| DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE: <u>June 2, 1955 Cath. Parley</u> | | | | 24. FUNERAL DIRECTOR: <u>Lassahn Funeral Home, 7401 Belair Rd.</u> | | | |

BUREAU V. S.

JUN 2 1955

RECEIVED

4468

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04454

Item 17, Film 181 5-19-55 et

CERTIFICATE OF DEATH

Reg. Dist. No. *X*

| | | | |
|---|--------------------------------|--|-------------------------|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY BALTIMORE | MARYLAND | STATE MARYLAND | COUNTY Baltimore |
| CITY (If outside corporate limits, write RURAL and give nearest town) | LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) | |
| TOWN FORT HOWARD | 1 HR. 50 Min. | TOWN BALTIMORE | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | STREET ADDRESS (If rural give location) | |
| VETERANS ADMINISTRATION HOSPITAL | | 2938 ELLIOTT STREET | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | 4. DATE (Month) (Day) (Year) | |
| RAYMOND J. SKOTARSKI | | MAY 11 1955 | |
| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: |
| MALE | WHITE | SINGLE | 8-17-20 |
| 9. AGE last birthday | | 10. BIRTHPLACE (State or foreign country): | |
| 34 yrs. | | BALTIMORE, MARYLAND | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): | | 12. CITIZEN OF WHAT COUNTRY? | |
| BARTENDER | | U. S. A. | |
| 13. FATHER'S NAME: | | 14. MOTHER'S MAIDEN NAME: | |
| JOHN SKOTARSKI | | KATHERINE MN: UNKNOWN | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| YES WW II | | 218-07-5388 | |
| 17. INFORMANT & ADDRESS: | | | |
| Clin. Rec., Vet. Adm., Ft. Howard, Md. | | | |
| 18. MEDICAL CERTIFICATION | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 581.0 | | UNKNOWN | |
| IMMEDIATE CAUSE | | | |
| CIRRHOSIS OF LIVER WITH SEVERE FATTY | | | |
| ANTECEDENT CAUSE (S): | | | |
| CHANGE | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | |
| (B) DUE TO | | | |
| (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | |
| 2 | | | |
| 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, street, office bldg., etc.) | |
| | | 21C. WHERE DID (City or town) (County) (State) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| VA M. | | 3:00 P.M. 4:50 P.M. | |
| 22. I hereby certify that I attended the deceased from MAY 11 1955 to MAY 11 1955 and that death occurred at 4:50 P.M. from the causes and on the date stated above. | | | |
| SIGNATURE WILLIAM B. VANDEGRIFT, M.D. | | ADDRESS M. DVAH, FORT HOWARD, MARYLAND | |
| DATE SIGNED 5-12-55 | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | NAME OF CEMETERY OR CREMATORY | |
| BURIAL | | ST. STANISLAUS CMEETERY | |
| DATE REC'D BY LOCAL REGISTRAR 5-13-55 | | LOCATION (City, town, or county) (State) | |
| REGISTRAR'S SIGNATURE W. B. Vandegrift | | BALTIMORE (DUNDALK) MD. | |
| 24. FUNERAL DIRECTOR | | ADDRESS | |
| MARIE E. FIALKOWSKI & SONS | | 1000 S. KENWOOD AVE., BALTIMORE, MD. | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MANUAL AND STATE OF THE STATE OF TEXAS

OFFICE OF THE ATTORNEY GENERAL

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4469

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04455

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY BALTO. | MARYLAND | STATE MD. | COUNTY BALTO. |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)
52 TOWN CATONSVILLE | LENGTH OF STAY (in this place)
26 yrs. | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
BALTO. | 3 Vol. 4 |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
14 SPRING GROVE STATE HOSPITAL | | STREET ADDRESS (If rural give location)
1424 N. EDEN ST. | ✓ |
| 3. NAME OF DECEASED: | | 4. DATE (Month) (Day) (Year) | |
| (First) BERTHA | (Middle) | (Last) SLADE | OF DEATH: 5-15-1955 |
| 5. SEX: F | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: about 1886 |
| | | | 9. AGE last birthday about 69 yrs. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): WISCONSIN |
| 13. FATHER'S NAME: John KAKALAY | | 14. MOTHER'S MAIDEN NAME: BERTHA THIEDA | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): 9 | | 16. SOCIAL SECURITY NO. | |
| 17. INTERMEDIATE ADDRESS: STELLA RAUCE LAUREL, MD. | | | |
| 18. MEDICAL CERTIFICATION | | | INTERVAL BETWEEN ONSET AND DEATH |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | |
| IMMEDIATE CAUSE 260X | | | |
| ANTECEDENT CAUSE (S): | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. | | | |
| (A) cerebrovascular accident | | | |
| DUE TO | | | |
| (B) hypertensive cerebrovascular | | | |
| DUE TO | | | |
| (C) disease - diabetes mellitus | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | |
| 0 | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| | | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from 7-11- , 19 29 , to 5-15- , 19 55 , that I last saw the deceased alive on 5-15- , 19 55 and that death occurred at 9 P M, from the causes and on the date stated above. | | | |
| SIGNATURE H. E. Edwards MD | | ADDRESS M. D. Spring Grove State Hosp. | |
| DATE SIGNED 5-15-55 | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town or county) (State) |
| Burial | 5/18/55 | Providence Cemetery | Baltimore Co., Maryland |
| DATE REC'D BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
| 5-17-55 | A. W. Hedrick | Wm. Cook Inc. | 1217 B. Paul St. |

WASHINGTON, D. C.

January 1, 1911

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 28th inst.

and in reply to inform you that the same has been forwarded to the

proper authorities for their consideration.

I am, Sir, very respectfully,

Yours very truly,

W. L. RORER

Secretary

Enclosed for you are two copies of a report

of the progress of the work of the Bureau of Plant Industry

during the year 1910.

I am, Sir, very respectfully,

Yours very truly,

W. L. RORER

Secretary

Very truly yours,

W. L. RORER

Secretary

Very truly yours,

W. L. RORER

Secretary

Very truly yours,

W. L. RORER

Secretary

Very truly yours,

W. L. RORER

Secretary

Very truly yours,

W. L. RORER

Secretary

Very truly yours,

W. L. RORER

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Very truly yours,

W. L. RORER

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Very truly yours,

W. L. RORER

Secretary

Very truly yours,

W. L. RORER

Secretary

Very truly yours,

W. L. RORER

Secretary

Very truly yours,

W. L. RORER

Secretary

Very truly yours,

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

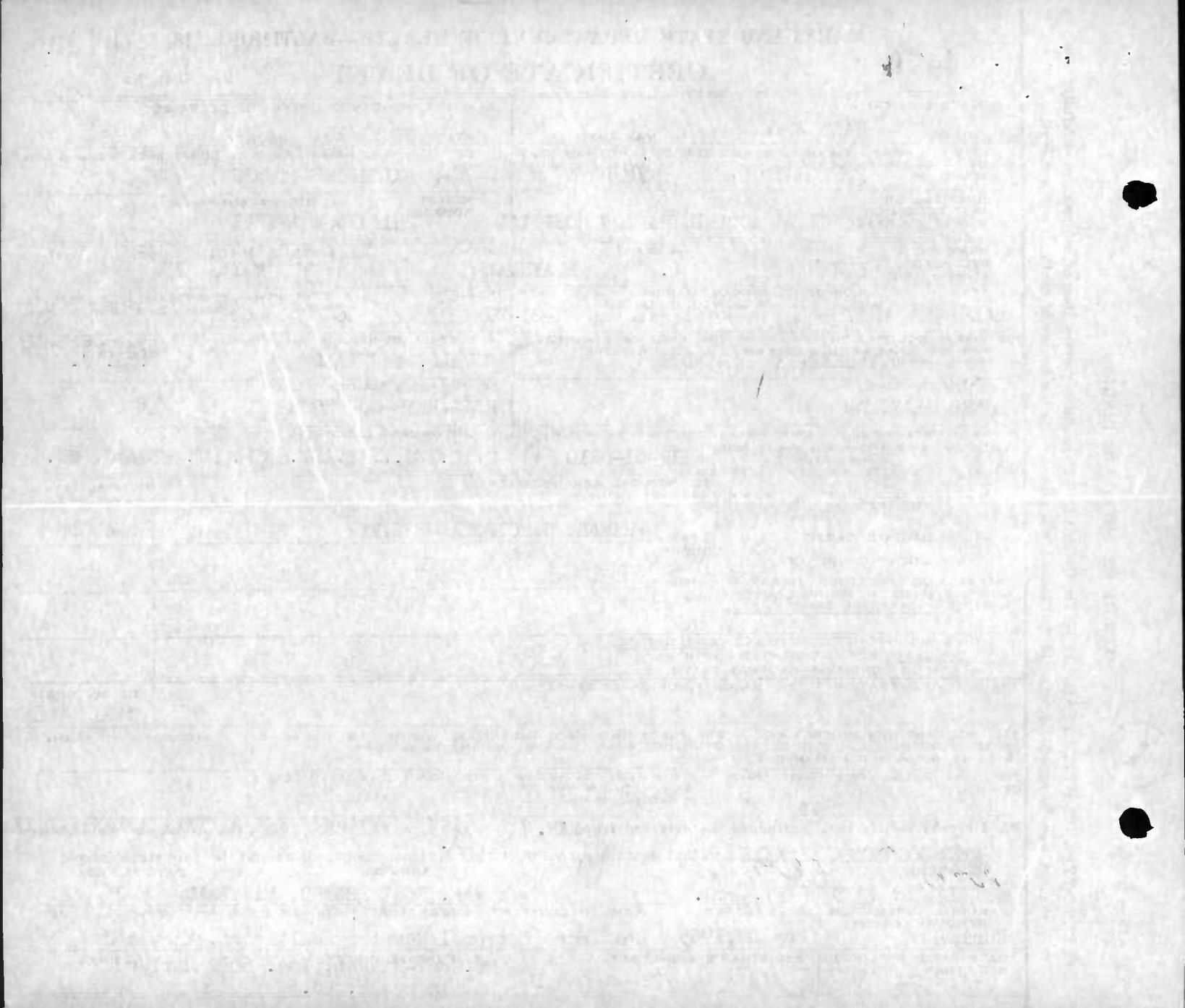
04456

4470

CERTIFICATE OF DEATH

Reg. Dist. No. *850*

| | | | | | | | |
|--|-------------------|--|-------------------|--|---------------------|---|----------------------|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY BALTIMORE | | MARYLAND | | STATE MARYLAND | | COUNTY | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) OR | | | |
| TOWN FORT HOWARD | | 79 DAYS | | TOWN BALTIMORE (TOWSON) | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL | | | | STREET ADDRESS (If rural give location) 251 RIDGE AVENUE | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | | | 4. DATE (Month) (Day) (Year) OF DEATH: | | | |
| EDWIN L. SLAYSMAN | | | | MAY 25 19 55 | | | |
| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH: | 9. AGE last birthday | 10. IF UNDER 1 YEAR | | 11. IF UNDER 24 MRS. |
| MALE | WHITE | MARRIED | 1-23-99 | 56 yrs. | Months | Days | Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY: | | 11. BIRTHPLACE (State or foreign country): | |
| TIMEKEEPER | | | | BENDIX | | GOVANS, MARYLAND | |
| 13. FATHER'S NAME: | | | | 14. MOTHER'S MAIDEN NAME: | | | |
| LONZO SLAYSMAN | | | | ELIZABETH SOUTHCOMB | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS: | |
| YES / WW I | | | | 219-01-6310 | | CLIN.REC., YET.ADM.HOSP. FT. HOWARD, MD. | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | UNKNOWN | |
| IMMEDIATE CAUSE (A) PRIMARY CARCINOMA OF LIVER | | | | | | | |
| ANTECEDENT CAUSE (B) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: | | | | 19B. MAJOR FINDINGS OF OPERATION | | | |
| 2 | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| VA M. | | | | | | | |
| 22. I hereby certify that I attended the deceased from MAR. 7 , 19 55 , to MAY 25 , 19 55 , that I last saw the deceased XXXXXX and that death occurred at 8:40 A. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE WILLIAM B. VANDEGRIFT, M.D. | | | | ADDRESS M. D. VAH, FORT HOWARD, MARYLAND | | | |
| DATE SIGNED 5-25-55 | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| Burial | | May 27, 1955 | | Baltimore National Cemetery | | Baltimore, Maryland | |
| DATE REC'D BY LOCAL REGISTRAR | | REGISTRAR'S SIGNATURE | | 24. FUNERAL DIRECTOR ADDRESS | | | |
| 5-26-55 | | W. H. Hedrick | | Wm. Cook-Blight, Inc. 6009 Harford Road Baltimore 14, Md. | | | |



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 04457

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY BALTIMORE | | MARYLAND | | STATE MARYLAND | | COUNTY | |
| CITY (If outside corporate limits, write RURAL or and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTIMORE | | | |
| X TOWN FORT HOWARD, | | 7 DAYS | | STREET ADDRESS (If rural give location) 620 SARAH ANN STREET | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL | | | | 50 | | | |
| 3. NAME OF DECEASED: (Type or Print) | | (First) ALBERT | | (Middle) B. | | (Last) SMITH | |
| 4. DATE OF DEATH: May 28 1955 | | 5. SEX: MALE | | 6. COLOR OR RACE: COLORED | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED | |
| 8. DATE OF BIRTH: 3-1-93 | | 9. AGE last birthday 62 yrs. | | 10. IF UNDER 1 YEAR Months | | 11. IF UNDER 24 HRS. Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER | | 10B. KIND OF BUSINESS OR INDUSTRY: CONTRACTING | | 11. BIRTHPLACE (State or foreign country): BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME: LOUIS SMITH | | | | 14. MOTHER'S MAIDEN NAME: MARY SMITH | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) YES 2 WW I | | | | 16. SOCIAL SECURITY NO. UNKNOWN | | 17. INFORMANT & ADDRESS: CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD. | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 1 WEEK Plus | |
| IMMEDIATE CAUSE (A) CEREBROVASCULAR ACCIDENT | | | | | | 1 | |
| ANTECEDENT CAUSE (B) HYPERTENSIVE CARDIOVASCULAR DISEASE | | | | | | UNKNOWN | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | | | | | |
| (C) OBSIDITY, ASTHMA, CIRRHOSIS OF LIVER | | | | | | UNKNOWN | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: 0 | | 19B. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) | | INJURY OCCUR? | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY VA M. | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from MAY 21, 1955 , to MAY 28, 1955 , and that death occurred at 6:05 AM , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE JAMES J. NOLAN, M.D. | | ADDRESS M. D. VAH, FORT HOWARD, MARYLAND | | DATE SIGNED 5-28-55 | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | DATE THEREOF May 31, 1955 | | NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery VAH, Baltimore, Maryland | | LOCATION (City, town, or county) (State) | |
| DATE REC'D BY LOCAL REGISTRAR 5-31-55 | | REGISTRAR'S SIGNATURE A. W. Hedrick | | FUNERAL DIRECTOR Arlington S. Phillips Funeral Home ADDRESS 1808 N. Monroe Street, Baltimore 17, Md. | | | |

STATE OF NEW YORK

IN SENATE

January 12, 1911

REPORT OF THE

COMMISSIONER OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE

ON JANUARY 10, 1911

ALBANY:

THE UNIVERSITY OF THE STATE OF NEW YORK PRESS

1911

1911

1911

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

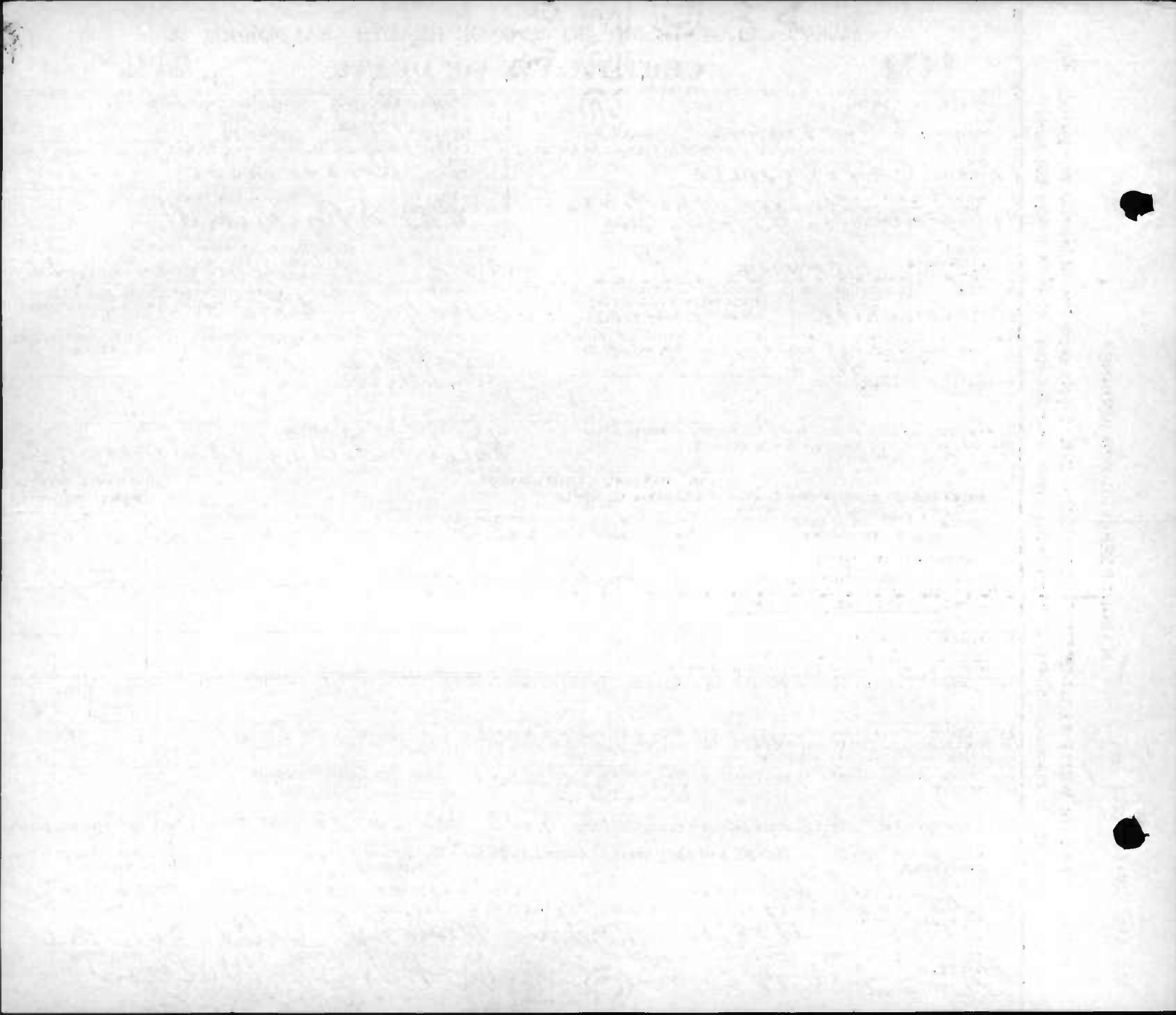
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4472

CERTIFICATE OF DEATH

Reg. Dist. No. 04458

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>BALTIMORE</u> | MARYLAND | STATE <u>MD</u> | COUNTY |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>52 CATONSVILLE</u> | LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE</u> | <u>3Y01-4</u> |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 HOUSE IN THE PINES 16 JUSTING AVE</u> | | STREET ADDRESS (If rural give location) <u>435 S. PARRISH ST</u> | |
| 3. NAME OF DECEASED: (First) <u>BERNICE</u> (Middle) <u>P.</u> (Last) <u>SMITH</u> | | 4. DATE OF DEATH (Month) <u>MAY</u> (Day) <u>25</u> (Year) <u>1955</u> | |
| SEX: <u>FEMALE</u> | 6. COLOR OR RACE: <u>WHITE</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u> | 8. DATE OF BIRTH: <u>FEB 6, 1907</u> |
| 9. AGE last birthday <u>48</u> yrs. | | IF UNDER 1 YEAR | IF UNDER 24 HRS. |
| | | Months | Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>SW</u> | | 10B. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): <u>BRISFIELD MD</u> |
| 12. CITIZEN OF WHAT COUNTRY? | | | |
| 13. FATHER'S NAME: <u>?</u> | | 14. MOTHER'S MAIDEN NAME: <u>?</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. | |
| 17. MEDICAL CERTIFICATION | | INFORMANT & ADDRESS: <u>Ralph M. Fullum 435 S. PARRISH ST</u> | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE <u>331X</u> | | | |
| (A) <u>Cerebral Hemorrhage</u> | | <u>4 PM.</u> | |
| ANTECEDENT CAUSE (S): | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | |
| (B) <u>Hypertension</u> | | <u>3 PM.</u> | |
| (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19A. DATE OF OPERATION: <u>0</u> | | 19B. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID (City or town) INJURY OCCUR? | (County) (State) |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>9-18, 1954</u> , to <u>5-25, 1955</u> , that I last saw the deceased alive on <u>5-25, 1955</u> , and that death occurred at <u>2:10 P.M.</u> from the causes and on the date stated above. | | | |
| SIGNATURE <u>William K. Gallagher</u> | | ADDRESS <u>M. D. Catonsville 28, Md.</u> | |
| DATE SIGNED <u>5-26-55</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> | DATE THEREOF <u>5/28/55</u> | NAME OF CEMETERY OR CREMATORY <u>Morland Memorial</u> | LOCATION (City, town, or county) (State) <u>Balto Co. Md.</u> |
| DATE REC'D BY LOCAL REGISTRAR <u>5-27-55</u> | REGISTRAR'S SIGNATURE <u>R. W. Heister</u> | 24. FUNERAL DIRECTOR <u>Robert B. M. Walters</u> | ADDRESS <u>TRAY STICKER STS</u> |



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4473

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04459

CERTIFICATE OF DEATH

Reg. Dist. No. 40

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Balt.</u> | | MARYLAND | | STATE <u>Md.</u> | | COUNTY <u>Balt.</u> | |
| CITY (If outside corporate limits, write OR and give nearest town) <u>Fork</u> | | RURAL LENGTH OF STAY (in this place) <u>70 yrs</u> | | CITY (If outside corporate limits, write OR and give nearest town) <u>Fork Md.</u> | | RURAL and give nearest town <u>X</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>L</u> | | | | STREET ADDRESS (If rural give location) <u>1</u> | | | |
| 3. NAME OF DECEASED: (First) <u>Joseph</u> (Middle) <u>Lester</u> (Last) <u>Smith</u> | | | | 4. DATE OF DEATH: (Month) <u>May</u> (Day) <u>21</u> (Year) <u>1955</u> | | | |
| 5. SEX: <u>M.</u> | | 6. COLOR OR RACE: <u>W.</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Widowed</u> | | 8. DATE OF BIRTH: <u>May 2-1875</u> | |
| 9. AGE last birthday: <u>80</u> yrs. | | 10. UNDER 1 YEAR | | 11. UNDER 24 HRS. | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Post Mach. Ret. post master</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY: <u>Md.</u> | | | |
| 13. FATHER'S NAME: <u>Joseph L. Smith</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY No.: <u>Joseph Smith Fork Md.</u> | | | |
| 17. INFORMANT & ADDRESS: <u>Joseph Smith Fork Md.</u> | | | | 18. MEDICAL CERTIFICATION | | | |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | Interval Between Onset And Death | | | |
| 443X Immediate cause <u>Ac. Bronchopneumonia</u> | | | | 4 days | | | |
| Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. | | | | 7 days | | | |
| DUE TO <u>Cerebral Thrombosis</u> | | | | 10 days | | | |
| DUE TO <u>Hypertensive Cardiovascular Dis.</u> | | | | | | | |
| DUE TO <u>Cardiac Decompensation</u> | | | | | | | |
| 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | | | |
| 19a. DATE OF OPERATION: <u>May 21-55</u> | | | | 19b. MAJOR FINDINGS OF OPERATION | | | |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | | |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | | PLACE (Home, farm, factory, street, OF office bldg., etc.) | | (CITY OR TOWN) | | (COUNTY) (STATE) | |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | | INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/> | | HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Nov. 10-35</u> to <u>May 21, 1955</u> , that I last saw the deceased alive on <u>May 21, 1955</u> and that death occurred at <u>8:45 PM</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Sifford P. Hudson M.D.</u> | | | | DATE SIGNED <u>5/23/55</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>May 28-55</u> | | <u>Fork Christian Cong.</u> | | <u>Fork Md.</u> | |
| DATE REC'D BY LOCAL REGISTRAR | | REGISTRAR'S SIGNATURE | | 24. FUNERAL DIRECTOR | | ADDRESS | |
| <u>May 24-55</u> | | <u>G. E. Arthur</u> | | <u>G. E. Arthur</u> | | <u>Fork Md.</u> | |
| | | <u>D. Fred Ro.</u> | | | | | |

BUREAU V. 3

JUN 7 1955

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

COUNTY

CITY (If outside corporate limits, write OR and give nearest town)

TOWN

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

4474

Baltimore County
Rural
Rogers Forge

203 Murdock Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

COUNTY

Maryland
Balto
CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWNSTREET
ADDRESS

(If rural give location)

203 Murdock Road

3. NAME OF
DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

Johnna Stahl

4. DATE
OF
DEATH

(Month)

(Day)

(Year)

MAY 10 - 1955

5. SEX

6. COLOR OR
RACE7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)

8. DATE OF BIRTH:

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

Female White

Widowed Jan 29 1867

88 yrs.

Months Days Hours Min.

10a. USUAL OCCUPATION. Give kind of
work done during most of working life,
even if retired:10b. KIND OF BUSINESS OR
INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT
COUNTRY?

Hollands

At Home

Germany

U.S.A.

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

Herman Messenwilder

Bertha Hammer

Louise Peusckel - 203 Murdock

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

No

Louise Peusckel - 203 Murdock

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X

Immediate cause

(a) UREMIA
DUE TO

Antecedent causes (s)

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last.(b) ARTERIO SCLEROTIC C.V. DISEASE - HYPERTEN
DUE TO

(c)

Interval Between
Onset And Death

10 DAYS

UNKNOWN

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

THYROID ADENOMA

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY ?

Yes ☐ No ☒21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,
OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURY m.INJURY OCCURRED
While at Not While
Work ☐ At Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from 1950, to MAY 10, 1955, that I last saw the deceased

alive on MAY 9, 1955, and that death occurred at 1:10 AM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Edward J. Zepner M.D. 427 Poplar Rd. Bayside 5/11/55

23. BURIAL, CREMATION
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial May 12-55

Lorraine Park Woodlawn - Md.

DATE REC'D BY LOCAL
REGISTRAR

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

5/11-55 J. B. Hippen 1300 Fawcett Pl.

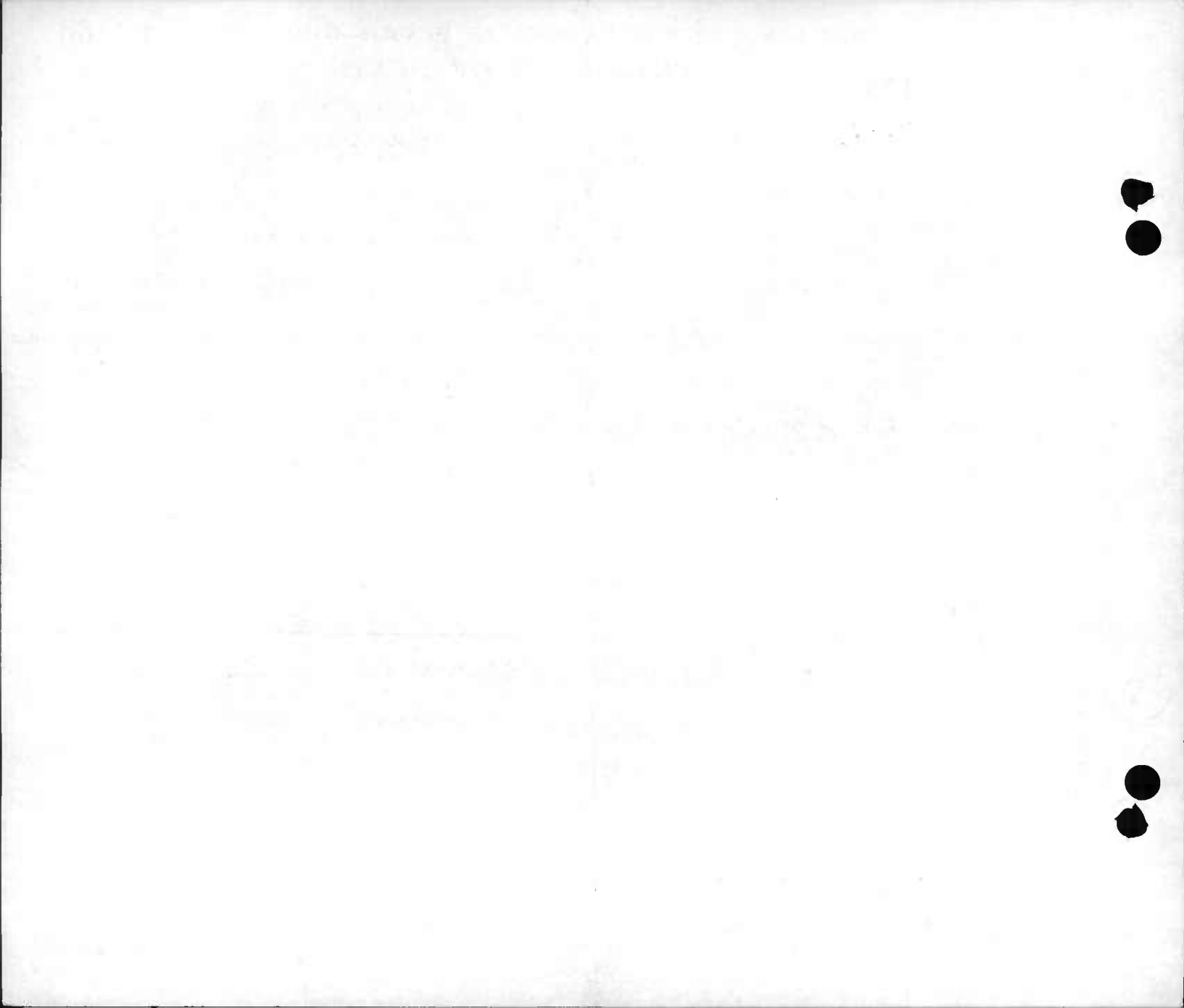
J. B. Hippen

17

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04461

4475

CERTIFICATE OF DEATH

Reg. Dist. No. 31

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH
COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED
STATE <u>Maryland</u> COUNTY <u>Baltimore</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rockdale</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rockdale</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3611 Washington Ave</u> | | STREET ADDRESS (If rural, give location) <u>3611 Washington Ave</u> | |
| 3. NAME OF DECEASED
(Type or Print) | (First) <u>Marshall</u> (Middle) <u>Bernard</u> (Last) <u>Streett</u> | 4. DATE OF DEATH | (Month) <u>May</u> (Day) <u>10</u> (Year) <u>1955</u> |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>Aug. 16, 1896</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u> | 9. AGE last birthday <u>58</u> yrs. | 11. BIRTHPLACE (State or foreign country) <u>Rocky Mount, N.C.</u> |
| 13. FATHER'S NAME <u>James P. Streett</u> | 14. MOTHER'S MAIDEN NAME <u>Dallas B. Streett</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | 16. SOCIAL SECURITY No. <u>214-01-9670</u> | 17. INFORMANT AND ADDRESS <u>M.D. Streett, 3611 Washington Ave, Rockdale, Md.</u> | |

| | | | |
|---|---|---|----------------------------------|
| 18. MEDICAL CERTIFICATION | | | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | |
| Immediate cause <u>180X</u> (a) <u>Generalized Carcinomatosis</u> | | | <u>One month</u> |
| Antecedent cause(s) (b) <u>Hypertension</u> | | | <u>2 years</u> |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) | | | |
| II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. | | | |
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 21. ACCIDENT (Specify) | PLACE (Home, farm, factory, street, OF office hldg., etc.) | (CITY OR TOWN) | (COUNTY) (STATE) |
| HOMICIDE | INJURY | | |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | HOW DID INJURY OCCUR? | |

22. I hereby certify that I attended the deceased from 3/10, 1949, to 5/10, 1955, that I last saw the deceased alive on 5/10, 1955, and that death occurred at 11:52 P. m., from the causes and on the date stated above.

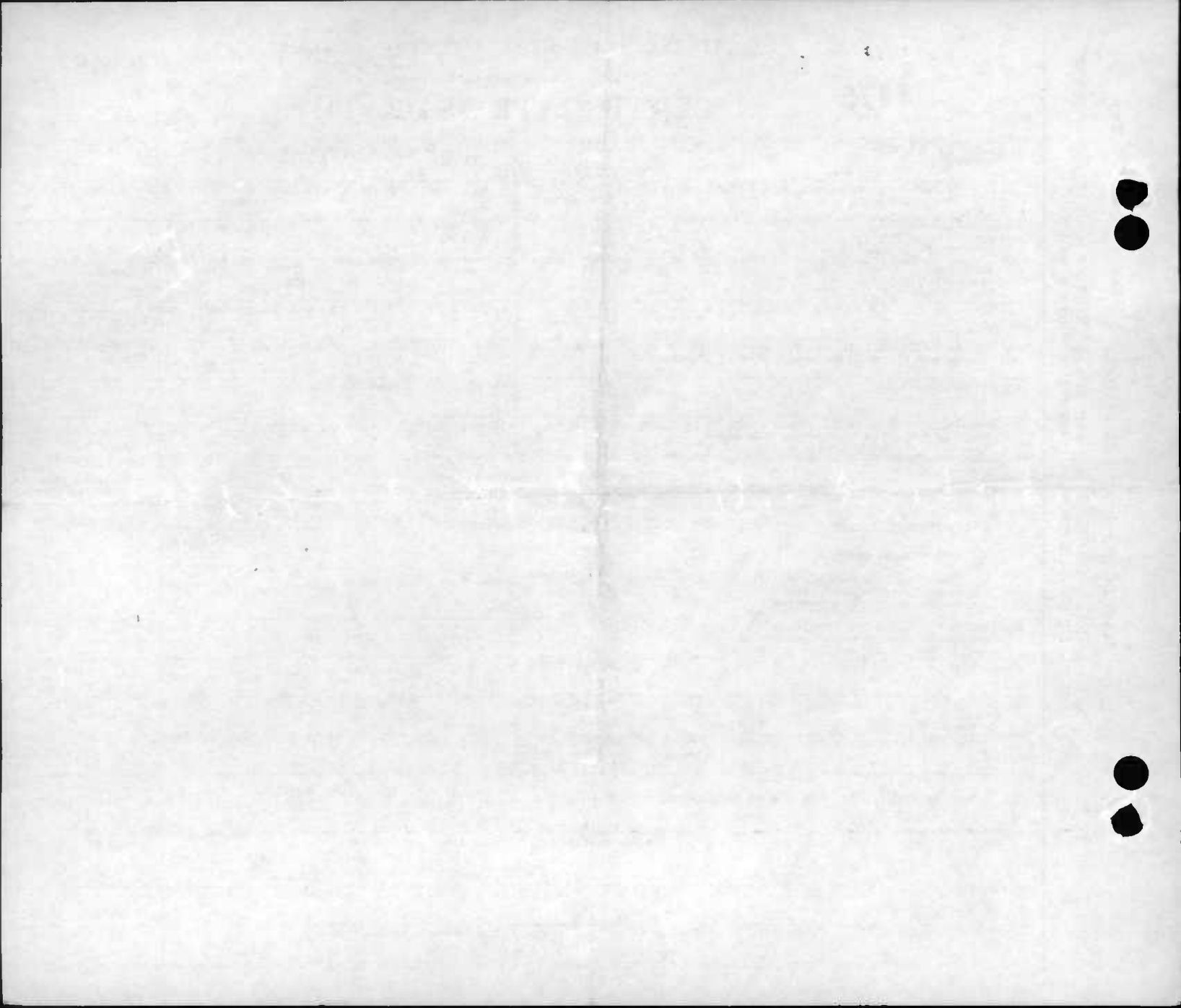
SIGNATURE Edwin Y. Simpson, M.D. ADDRESS 8204 Liberty Rd, Balto 7, Md. DATE SIGNED 5/10/55

| | | | |
|--|---|---|---|
| 23. BURIAL CREMATION REMOVAL (Specify) | DATE <u>May 14 1955</u> | NAME OF CEMETERY OR CREMATORY <u>St. Charles Cemetery</u> | LOCATION (City, town, or county) <u>Rockdale, Md.</u> |
| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE <u>Wm. H. DeBorja</u> | 24. FUNERAL DIRECTOR <u>Willis L. Moore</u> | ADDRESS <u>4510 Liberty Hgts. Ave.</u> |

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4339 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04462

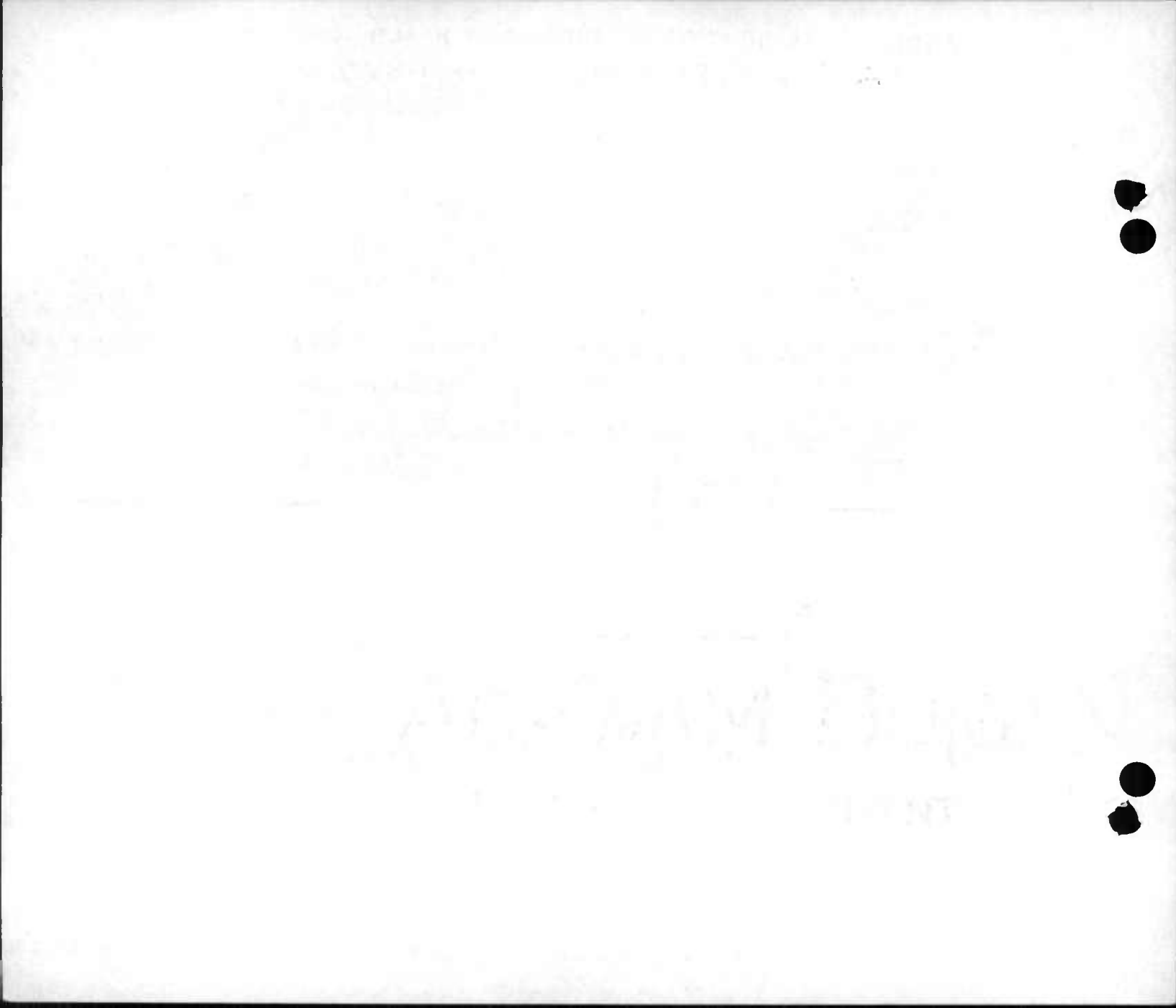
Item 14, Film G182, 6/9/55 fcy

Reg. Dist. No.

| | | | | | | | |
|--|--------------------------------|--|--|--|---------------------|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>BALTIMORE</u> | | MARYLAND | | STATE <u>MARYLAND</u> | | COUNTY <u>BALTO.</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>53 DUNDALK</u> | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>53 DUNDALK</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00 55 NORTHSHIP</u> | | | | STREET ADDRESS (If rural give location) <u>55 NORTHSHIP</u> | | | |
| 3. NAME OF DECEASED: (First) <u>IDA</u> (Middle) <u>BELL</u> (Last) <u>STUMP</u> | | 4. DATE OF DEATH: <u>MAY 30</u> 19 <u>55</u> | | | | | |
| 5. SEX: <u>FEMALE</u> | 6. COLOR OR RACE: <u>WHITE</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u> | 8. DATE OF BIRTH: <u>APRIL 5, 1876</u> | 9. AGE last birthday: <u>79</u> yrs. | 10. IF UNDER 1 YEAR | 11. IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>At Home</u> | | 10b. KIND OF BUSINESS OR INDUSTRY: | | 11. BIRTHPLACE (State or foreign country): <u>PENNA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME: <u>MICHAEL KERN</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Amanda Cooper</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>NO</u> (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY No.: <u>-</u> | | 17. INFORMANT & ADDRESS: <u>RALPH F. MATTOX 55 NORTHSHIP</u> | | | |

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 18. MEDICAL CERTIFICATION | | | | | | Interval Between Onset And Death | |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| Immediate cause (a) <u>181X Carcinomatosis.</u> | | | | | | <u>2 mts</u> | |
| Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Carcinoma gall bladder</u> | | | | | | <u>one year</u> | |
| (c) | | | | | | | |
| 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | | | |
| 19a. DATE OF OPERATION: <u>0</u> | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 21. ACCIDENT (Specify) <u>HOMICIDE</u> | | PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u> | | (CITY OR TOWN) | | (COUNTY) (STATE) | |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from Jan. <u>1944</u> , to <u>May 30</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 30</u> , 19 <u>55</u> , and that death occurred at <u>8:20 P.M.</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>David A. Auduw MD</u> | | (Degree or title) | | ADDRESS <u>33 Dundalk Ave Dundalk Md</u> | | DATE SIGNED <u>5/31/55</u> | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | DATE THEREOF <u>JUNE 3, 1955</u> | | NAME OF CEMETERY OR CREMATORY <u>MEADOW RIDGE</u> | | LOCATION (City, town, or county) (State) <u>ELK RIDGE MD</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>6-1-55</u> | | REGISTRAR'S SIGNATURE <u>R. W. Keckler</u> | | 24. FUNERAL DIRECTOR <u>ULLRICH FUNERAL HOME</u> | | ADDRESS <u>DUNDALK</u> | |

RE



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04463

4476

CERTIFICATE OF DEATH

Reg. Dist. No. 37

| | | | |
|---|--|--|--------------------------------------|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>Baltimore</u> | MARYLAND | STATE <u>Md.</u> | COUNTY <u>3Y01-4</u> |
| CITY (If outside corporate limits, write RURAL and give nearest town) | LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) | OR |
| TOWN <u>Dorchester Md</u> | <u>7 yrs 10 mo</u> | TOWN <u>Baltimore Md</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | STREET ADDRESS (If rural give location) | |
| <u>90 Macovic Home</u> | | <u>729 W. 34th St</u> | |
| 3. NAME OF DECEASED: | | 4. DATE OF DEATH: | |
| (Type or Print) <u>Susie Mason Taylor</u> | | (Month) (Day) (Year) | |
| 5. SEX: <u>Female</u> | 6. COLOR OR RACE: <u>White</u> | 7. SINGLE <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> (Specify): | 8. DATE OF BIRTH: <u>Jan 19-1861</u> |
| 9. AGE last birthday: <u>94</u> yrs. | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u> | 11. BIRTHPLACE (State or foreign country): <u>Fredricksburg Va</u> | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME: <u>John T. Drington</u> | | 14. MOTHER'S MAIDEN NAME: <u>Sophia Withers</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY No. <u>None</u> | |
| 17. INFORMANT & ADDRESS: <u>Laura H. Schroeder</u> | | | |
| 18. MEDICAL CERTIFICATION | | | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | |
| 422.1 IMMEDIATE CAUSE (A) <u>Cardio Vascular Disease</u> | | | <u>1 yr?</u> |
| ANTECEDENT CAUSE (B) <u>Arterio sclerosis</u> | | | <u>5 yrs</u> |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19A. DATE OF OPERATION: <u>0</u> | | 19B. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| 21C. WHERE DID (City or town) (County) (State) | | 21D. HOW DID INJURY OCCUR? | |
| 21E. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 22. I hereby certify that I attended the deceased from <u>Dec 1947</u> to <u>May 21, 1953</u> , that I last saw the deceased alive on <u>May 21</u> , 1953, and that death occurred at <u>3:00 P.M.</u> from the causes and on the date stated above. | | | |
| SIGNATURE <u>Walter T. Lees</u> | | DATE SIGNED <u>23 May 1953</u> | |
| M. D. <u>Cockeyville</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) | | 24. NAME OF CEMETERY OR CREMATORY | |
| <u>Buried</u> | | <u>St. Marys Cemetery, Hampden, Balto Md</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>May 24, 1953</u> | | REGISTRAR'S SIGNATURE <u>L. M. Schroeder</u> | |
| FUNERAL DIRECTOR <u>Paul Chenoweth</u> | | ADDRESS <u>3665 Chestnut Ave</u> | |

TWO FOR ONE CERTIFICATE - FILM GL82 - 5/27/55 - mb

(Copies given from other certificate)

BUREAU V. S.

MAY 26 1955

RECEIVED

4477

MARYLAND STATE DEPARTMENT OF HEALTH

04464

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 37

| | | | |
|--|-------------------------------|---|--|
| 1. PLACE OF DEATH - COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Baltimore</u> | |
| CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Cockeysville</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Paper Mill & Ashland Rds.</u> | | STREET ADDRESS (If rural, give location) <u>Paper Mill & Ashland Roads</u> | |
| 3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>CUYLER LEONARD THOMPSON</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>May 6, 1955</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>Aug. 18, 1898</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanist</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Tool Maker</u> | 9. AGE last birthday <u>56</u> yrs. If under 1 year Months Days Hours Min. |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>John M. Thompson</u> | | 14. MOTHER'S MAIDEN NAME <u>Annie M. Keane</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>17</u> | | 16. SOCIAL SECURITY NO. <u>17</u> | |
| 17. INFORMANT <u>Harvey Thompson, 505 Walker Ave, Baltimore 12, Md.</u> | | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
Immediate cause

(a)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

SuddenII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

REG 9 May 1955Dr. Annistead MacRaeE. Madison Mitchell,Havre de Grace

MARGIN RESERVED FOR BINDING

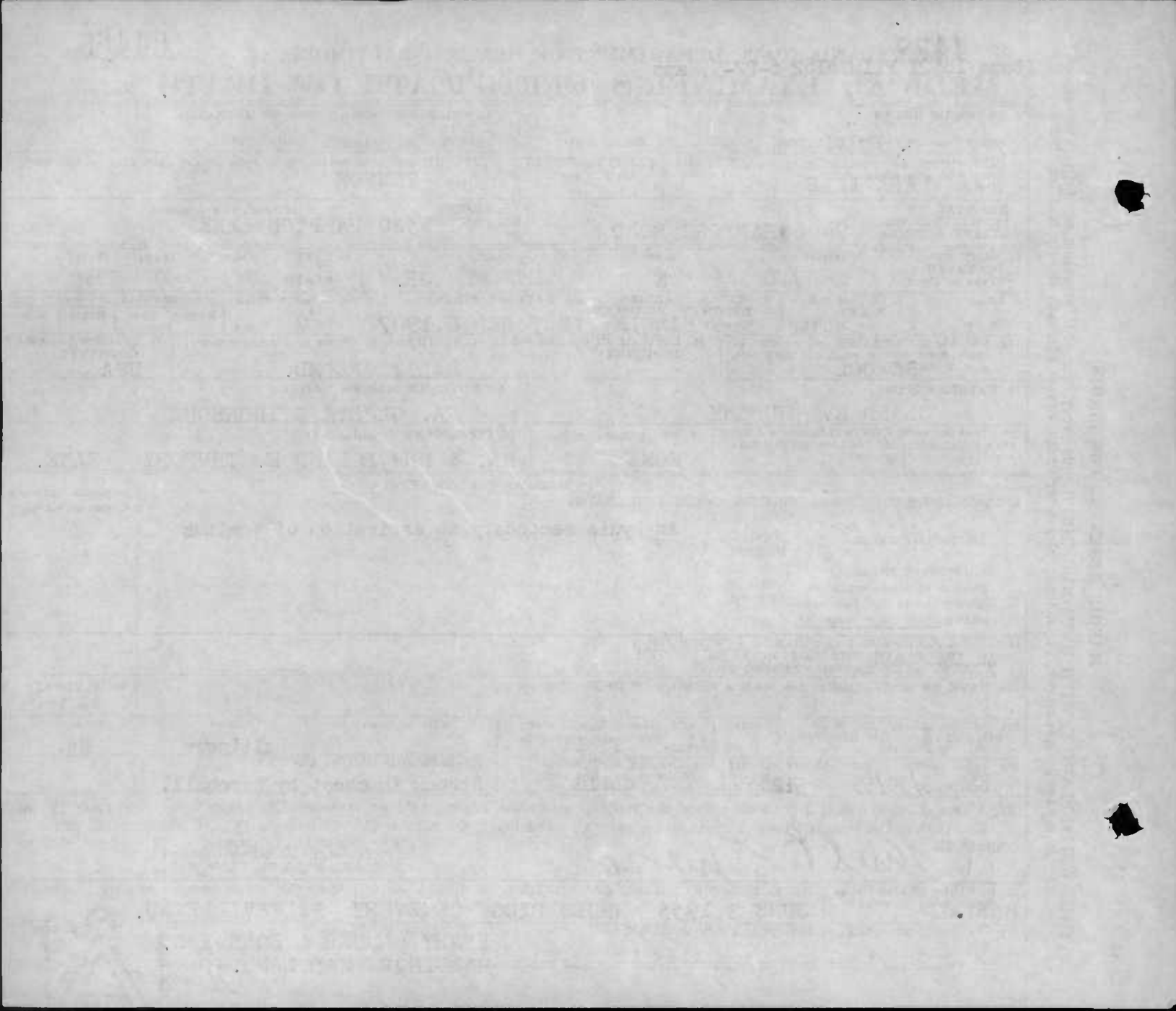
VS. A15A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 11 1955
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

| 4478 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | 04465 Reg. Dist. | | | |
|---|--|-------------------|--|--|--|-----------------------------------|-------|--|----------|----------------------------------|--------|------------------------------|------------------|
| Items 18&21 Film G182 6-22-55 ans | | | | | | | | | | No. 39 | | | |
| 1. PLACE OF DEATH: | | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | | | | | | |
| COUNTY | | Baltimore | | | MARYLAND | | STATE | | Maryland | | COUNTY | | Balto. |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | | | | LENGTH OF STAY (in this place) | | | CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN | | | | | TOWSON |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | | 9400 HARFORD ROAD | | | STREET ADDRESS (If rural, give location) | | | | | 520 HAMPTON LANE |
| 3. NAME OF DECEASED: | | (First) | | (Middle) | | (Last) | | 4. DATE OF DEATH | | (Month) | | (Day) (Year) | |
| | | ROLAND | | E | | THURSBY JR. | | May | | 30 | | 1955 | |
| 5. SEX: | | 6. COLOR OR RACE: | | 7. SINGLE. MARRIED, WIDOWED, DIVORCED, (Specify) | | 8. DATE OF BIRTH: | | 9. AGE last birthday: | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Male | | White | | SINGLE | | OCTOBER 8, 1947 | | 7 yrs. | | Months | | Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY: | | | | 11. BIRTHPLACE (State or foreign country): | | | | 12. CITIZEN OF WHAT COUNTRY? | |
| SCHOOL | | | | | | | | BALTIMORE MD. | | | | USA | |
| 13. FATHER'S NAME: | | | | | | 14. MOTHER'S MAIDEN NAME: | | | | | | | |
| ROLAND E. THURSBY | | | | | | A. GLORIA STINCHECUM | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | | | | 16. SOCIAL SECURITY No.: | | 17. INFORMANT & ADDRESS: | | | | | | | |
| 4 NO | | | | NONE | | MR. & MRS ROLAND E. THURSBY SAME. | | | | | | | |
| 18. MEDICAL CERTIFICATION | | | | | | | | | | | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 936.4 Immediate cause (a) Asphyxia secondary to aspiration of vomitus | | | | | | | | | | | | | |
| DUE TO | | | | | | | | | | | | | |
| Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO | | | | | | | | | | | | | |
| stating underlying cause last (c) | | | | | | | | | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION: | | | | 19b. MAJOR FINDING OF OPERATION: | | | | | | | | | |
| | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY) | | | | 21c. (City or town) (County) (State) | | | | | |
| | | | | field | | | | Baltimore Md. | | | | | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY | | | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | 21f. HOW DID INJURY OCCUR? | | | | | |
| 5/30/55 5:20p M. | | | | | | | | Struck in chest by baseball. | | | | | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | | | | | |
| SIGNATURE | | | | Paul P. Grew | | | | CHIEF MEDICAL EXAMINER | | | | | |
| | | | | | | | | DEPUTY MEDICAL EXAMINER | | | | | |
| | | | | | | | | M. D. ASSISTANT MEDICAL EXAM. | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): | | | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) | | (State) | | | |
| BURIAL | | | | JUNE 3, 1955 | | DRUID RIDGE CEMETERY | | PIKESVILLE MD. | | | | | |
| DATE REC'D BY LOCAL REG. | | | | REGISTRAR'S SIGNATURE | | | | 24. FUNERAL DIRECTOR | | ADDRESS | | | |
| 6-2-55 | | | | A. P. Grew | | | | HENRY SANDER & SONS INC. | | | | | |
| | | | | | | | | BALTIMORE MARYLAND. | | George Sander | | | |



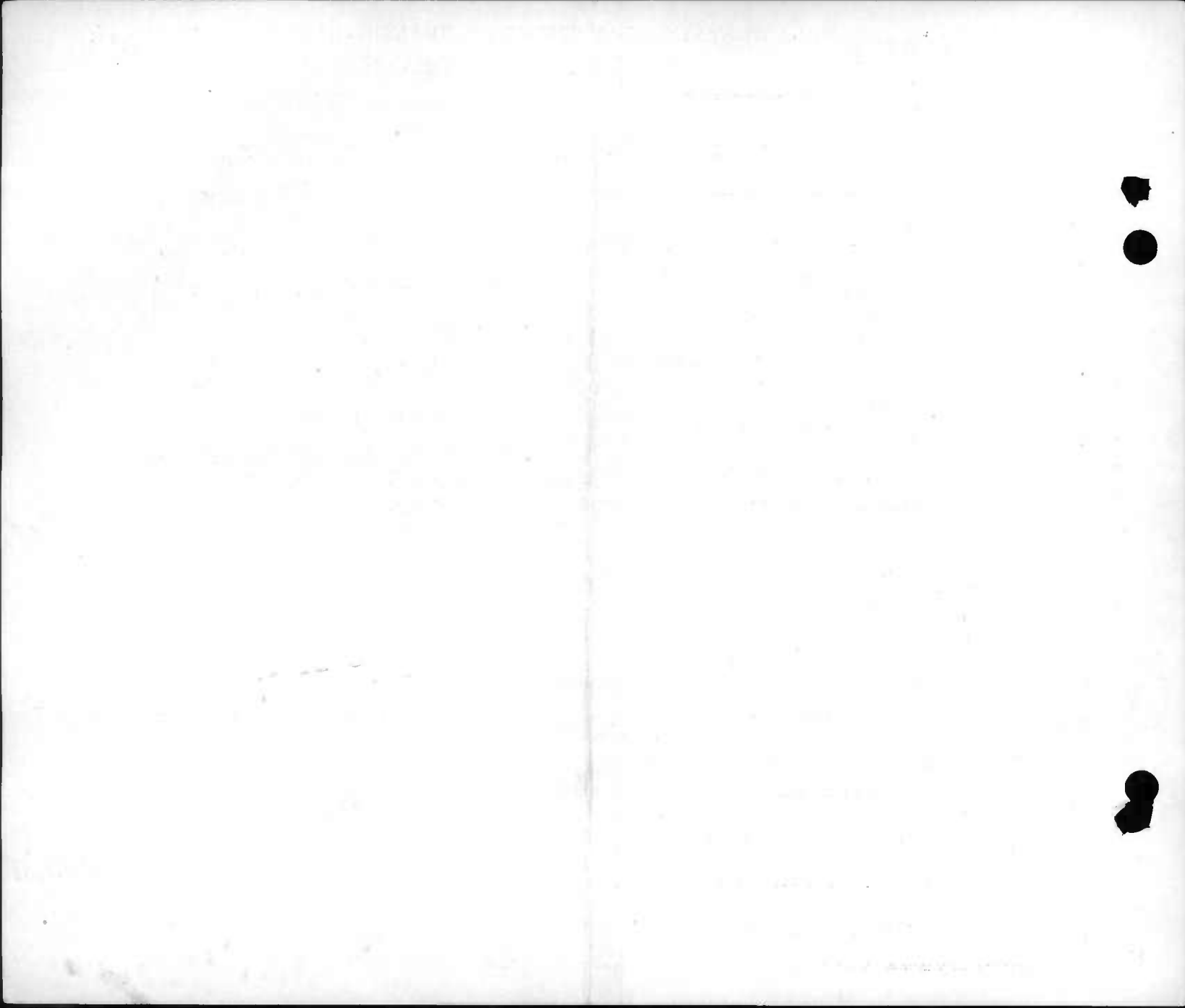
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4479 CERTIFICATE OF DEATH

Reg. Dist. No. 04466

| | | | | | | | |
|---|-----------------------------------|---|--|---|---|---|------------------|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY Baltimore | | MARYLAND | | STATE Md. | | COUNTY | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)
X TOWN Rodgers Forge | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town)
OR TOWN Rodgers Forge | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
320 Murdock Road | | | | STREET ADDRESS (If rural, give location)
320 Murdock Road | | | |
| 3. NAME OF DECEASED: | | | | 4. DATE OF DEATH: | | | |
| (First) Bessie | | (Middle) Bell | | (Last) Waesche | | (Month) May (Day) 28, (Year) 19 55 | |
| 5. SEX:
Female | 6. COLOR OR RACE:
White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married | 8. DATE OF BIRTH:
Sept. 26, 1879 | 9. AGE last birthday:
75 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): | | | | 10b. KIND OF BUSINESS OR INDUSTRY:
Housewife | | 11. BIRTHPLACE (State or foreign country):
Baltimore, Md. | |
| 13. FATHER'S NAME:
John C. Bell | | | | 14. MOTHER'S MAIDEN NAME:
Elizabeth Moore | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY No.: | | 17. INFORMANT & ADDRESS:
J. Edward Waesche 320 Murdock Road | |
| 18. MEDICAL CERTIFICATION | | | | | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 420.1
Immediate cause (a) Cornary Occlusion
DUE TO
Antecedent cause(s) (b) Arterio sclerosis
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) | | | | | | Immediate | |
| II. OTHER SIGNIFICANT CONDITIONS:
Conditions contributing to the death but not related to the disease or condition causing death. | | | | | | | |
| 19a. DATE OF OPERATION: | | | | 19b. MAJOR FINDINGS OF OPERATION: | | | |
| 21. ACCIDENT (Specify) | | PLACE (Home, farm, factory, street, OF office bldg., etc.) | | (CITY OR TOWN) | | (COUNTY) (STATE) | |
| SUICIDE
HOMICIDE | | INJURY | | | | | |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | | INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at..... A..... M., from the causes and on the date stated above. | | | | | | | |
| SIGNATURE [Signature] | | | | (DEGREE OR TITLE) ADDRESS M.D. 6201 York Rd Baltimore Md | | DATE SIGNED 28 May 55 | |
| 23. BURIAL, CREMATION REMOVAL (Specify):
Burial | | DATE THEREOF
May 31, 1955 | | NAME OF CEMETERY OR CREMATORY
St. Thomas | | LOCATION (City, town, or county) (State)
Garrison Forest, Md. | |
| DATE REC'D BY LOCAL REG.
5-31-55 | | REGISTRAR'S SIGNATURE
A. W. Hedgcock | | 24. FUNERAL DIRECTOR
John O. Mitchell & Son | | | |



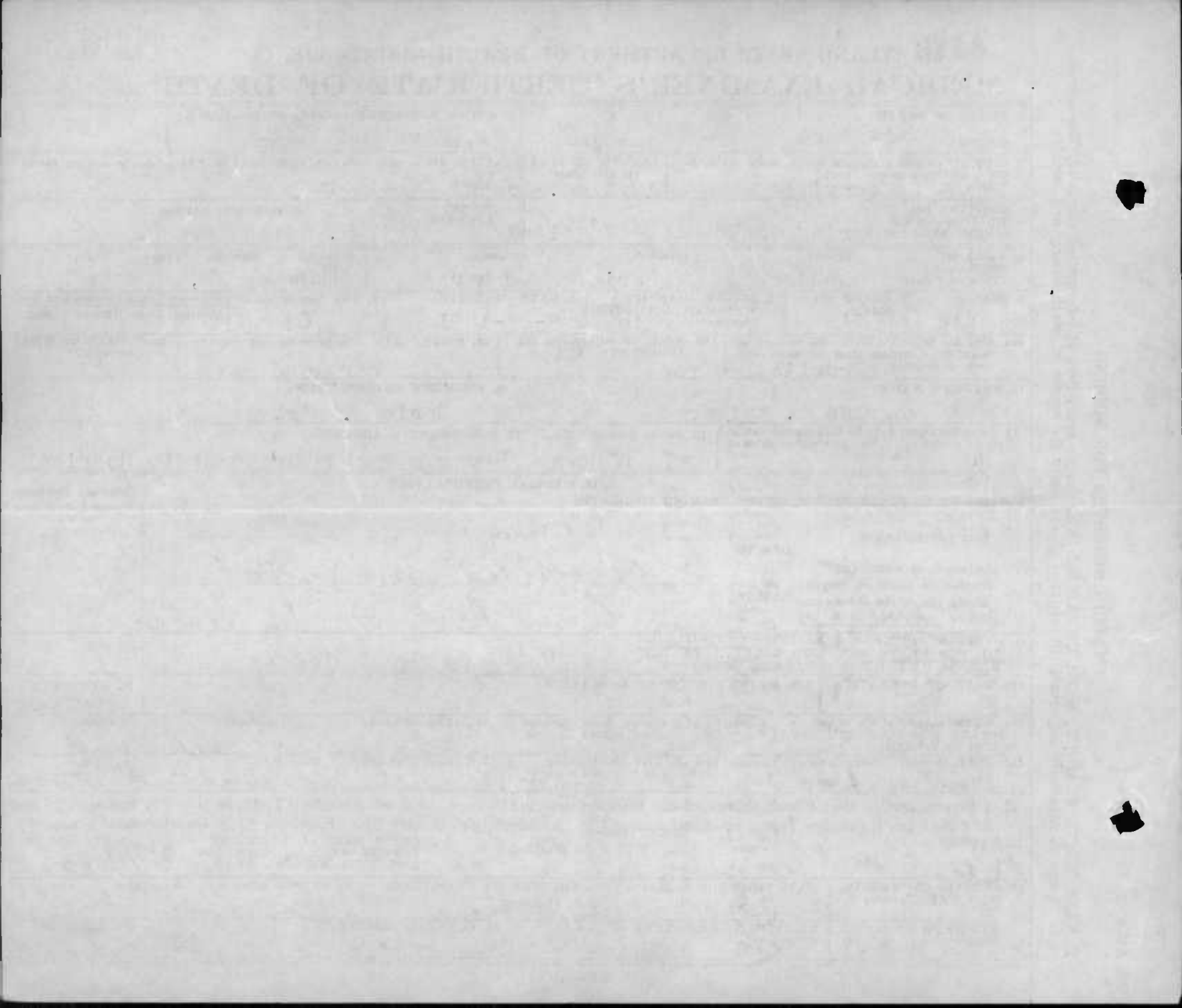
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death, clearly and legibly.

4480 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

04467
Reg. Dist.

| | | | | | | | |
|--|--------------------------------|--|------------------------------------|---|---|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Baltimore</u> | | STATE <u>Maryland</u> | | COUNTY | | | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)
TOWN <u>Catonsville</u> | | LENGTH OF STAY (in this place)
<u>1 yr 11 mo. 25 days</u> | | CITY (If outside corporate limits write RURAL and give nearest town)
OR
TOWN <u>Baltimore</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u> | | | | STREET ADDRESS (If rural, give location)
<u>1137 N. Fulton Avenue</u> | | | |
| 3. NAME OF DECEASED: (First) <u>Louise</u> | | (Middle) <u>Marie</u> | | (Last) <u>Walker</u> | | 4. DATE OF DEATH <u>May 24,</u> 19 <u>55</u> | |
| 5. SEX: <u>Female</u> | 6. COLOR OR RACE: <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u> | 8. DATE OF BIRTH: <u>9-27-1891</u> | 9. AGE last birthday: <u>63</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Practical nurse</u> | | 10b. KIND OF BUSINESS OR INDUSTRY: | | 11. BIRTHPLACE (State or foreign country): <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME: <u>Charles W. Walker</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Marie L. Kirby</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> | | 16. SOCIAL SECURITY No.: <u>Unknown</u> | | 17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hospital</u> | | | |

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | | 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| <u>917.7</u>
Immediate cause (a) <u>Toxemia</u>
DUE TO
Antecedent cause(s) (b) <u>Body scalded on 3/2 body</u>
Diseases or conditions, if any, giving rise to the above cause DUE TO
stating underlying cause last (c) <u>Lower part 2nd degree burn</u> | | | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetic Mellitus</u> | | | | | | | |
| 19a. DATE OF OPERATION: | | 19b. MAJOR FINDING OF OPERATION: | | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Asphyx</u> | | 21c. (City or town) <u>Catonsville</u> (County) <u>Balls Blad</u> (State) <u>Md</u> | | | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>May 16 53 12 M.</u> | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? <u>Scalded herself in bath tub heated with</u> | | | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .
SIGNATURE <u>Wes S M Kieffer</u> 1010 Leach <u>1010 Leach</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>May 24 55</u>
M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/> | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>may 26 1955</u> | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u> | | LOCATION (City, town, or county) (State) <u>Baltimore Md</u> | |
| DATE REC'D BY LOCAL REG <u>5-20-55</u> | | REGISTRAR'S SIGNATURE <u>Wes S M Kieffer</u> | | 24. FUNERAL DIRECTOR <u>Wm Cook Inc - 1217 St Paul St</u> | | ADDRESS | |



4340

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>BALTO</u> | | MARYLAND | | STATE <u>md</u> | | COUNTY <u>BALTO</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | OR | |
| 53 TOWN <u>DUNDALK</u> | | 1 YR. | | TOWN <u>DUNDALK (22)</u> | | 53 | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| 00 <u>2617 YORKWAY</u> | | | | <u>2617 YORKWAY</u> | | | |
| 3. NAME OF DECEASED: | | (First) | | (Middle) | | (Last) | |
| (Type or Print) | | <u>EDITH</u> | | <u>MARY</u> | | <u>WALSH</u> | |
| 5. SEX: | | 6. COLOR OR RACE: | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | | 8. DATE OF BIRTH: | |
| <u>FEM.</u> | | <u>WHITE</u> | | <u>WIDOW</u> | | <u>NOV. 27, 1879</u> | |
| 9. AGE last birthday: | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | 10. CITIZEN OF WHAT COUNTRY? | |
| 75 yrs. | | Months | | Days | | Hours | |
| 5-20- | | 1955 | | | | U.S.A. | |
| 10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): | | | | 10b. KIND OF BUSINESS OR INDUSTRY: | | 11. BIRTHPLACE (State or foreign country): | |
| <u>HOUSEWIFE</u> | | | | | | <u>NEW JERSEY</u> | |
| 13. FATHER'S NAME: | | | | 14. MOTHER'S MAIDEN NAME: | | | |
| <u>PETER PETERSON</u> | | | | <u>MARY CHRISTENSEN</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | | | | 16. SOCIAL SECURITY No.: | | 17. INFORMANT & ADDRESS: | |
| <u>4 NO</u> | | | | <u>NONE</u> | | <u>MRS. M.M. SHARPE - SAME ADDRESS</u> | |
| 18. MEDICAL CERTIFICATION | | | | | | | |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | Interval Between Onset And Death | |
| Immediate cause (a) <u>Carcinoma of left breast.</u> | | | | | | 6-7 months | |
| Antecedent causes (s) (b) <u>Hypertension, arteriosclerosis, Cardio-vascular disease.</u> | | | | | | 4-5 years | |
| DUE TO | | | | | | | |
| DUE TO | | | | | | | |
| DUE TO | | | | | | | |
| 11. OTHER SIGNIFICANT CONDITIONS | | | | | | | |
| Conditions contributing to the death but not related to the disease or condition causing death. | | | | | | | |
| 19a. DATE OF OPERATION: | | | | 19b. MAJOR FINDINGS OF OPERATION | | | |
| | | | | | | | |
| 21. ACCIDENT (Specify) | | PLACE (Home, farm, factory, street, OF office bldg., etc.) | | (CITY OR TOWN) | | (COUNTY) | |
| SUICIDE | | INJURY | | | | (STATE) | |
| HOMICIDE | | | | | | | |
| TIME (Month) (Day) (Year) (Hour) | | INJURY OCCURRED | | HOW DID INJURY OCCUR? | | | |
| OF INJURY | | While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I hereby certify that I attended the deceased from <u>Sept. 1954</u> , to <u>May 20, 1955</u> , that I last saw the deceased alive on <u>May 20, 1955</u> , and that death occurred at <u>6:15 AM</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | | | DATE SIGNED | | | |
| <u>Eugene F. Neary MD.</u> | | | | <u>5-24-55</u> | | | |
| (Degree or title) | | | | ADDRESS | | | |
| <u>7001 Morningland Rd. Dundalk 22, Md.</u> | | | | | | | |
| 23. BURIAL, CREMATION, OR OTHER (Specify) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) | |
| <u>Burial</u> | | <u>5-23-55</u> | | <u>oak lawn</u> | | <u>BALTO. Co., Md.</u> | |
| DATE REC'D BY LOCAL REGISTRAR | | REGISTRAR'S SIGNATURE | | 24. FUNERAL DIRECTOR | | ADDRESS | |
| <u>MAY 21 1955</u> | | <u>William M. Kelly</u> | | <u>Walter Brock Bradley, Dundalk, Md.</u> | | | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 24 1965
BUREAU V. S.

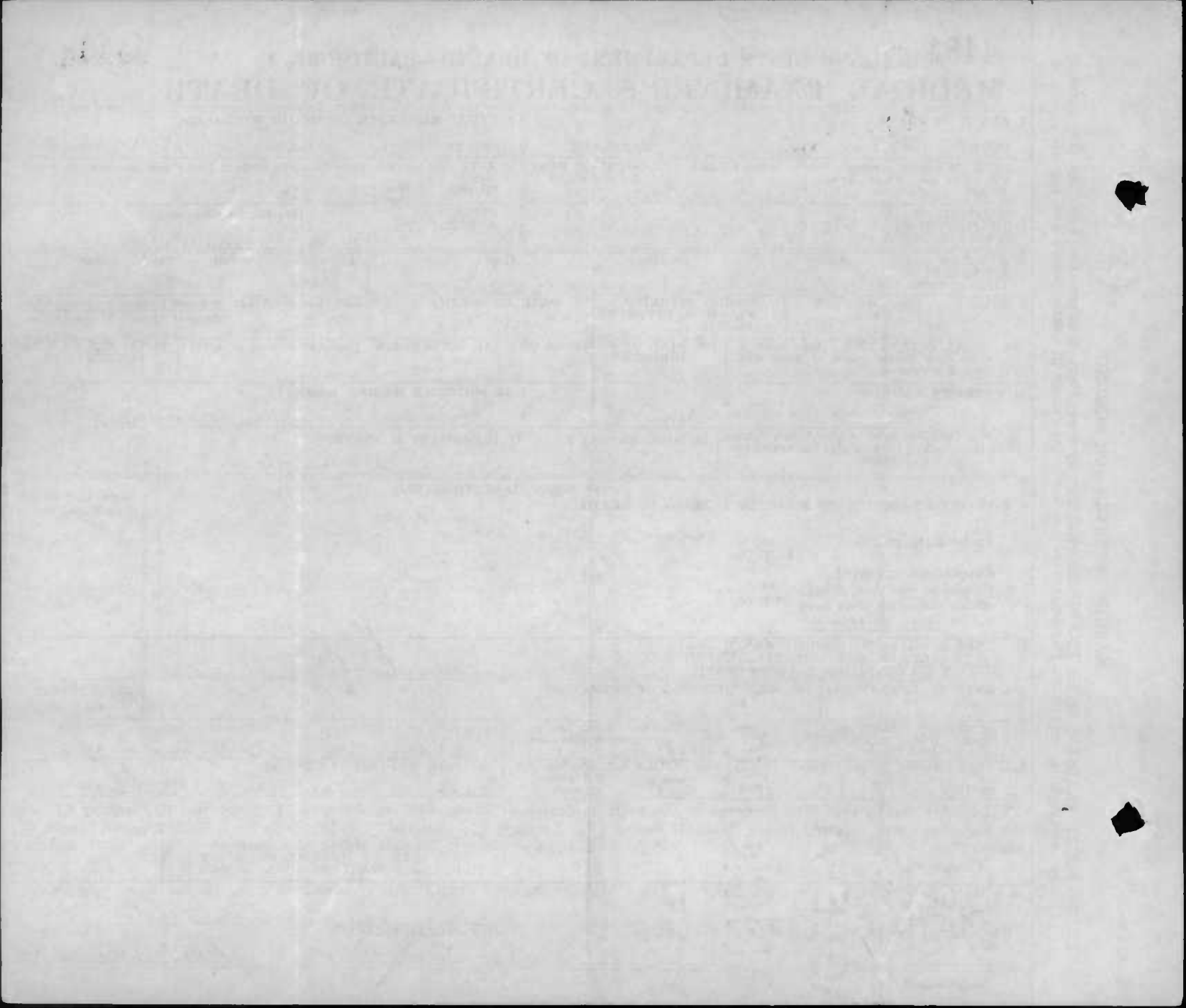
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4481 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04469

| | | | |
|---|--------------------------------|---|---|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>BALTIMORE</u> | MARYLAND | STATE <u>MD</u> | COUNTY <u>BALTIMORE</u> |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | LENGTH OF STAY (in this place) | CITY (If outside corporate limits write RURAL and give nearest town) | |
| TOWN <u>CATONSVILLE</u> | <u>1 year, 11 mos</u> | TOWN <u>BALTIMORE</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | STREET ADDRESS | (If rural, give location) |
| <u>14 SPRING GROVE ST. Hvy.</u> | | <u>8014 Eastern Av.</u> | |
| 3. NAME OF DECEASED: | | 4. DATE OF DEATH | |
| (First) <u>Mary</u> | (Middle) <u>Ellen</u> | (Last) <u>Wheatley</u> | (Month) <u>5</u> (Day) <u>29</u> (Year) <u>1955</u> |
| 5. SEX: <u>F</u> | 6. COLOR OR RACE: <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u> | 8. DATE OF BIRTH: <u>8-15-1879</u> |
| 9. AGE last birthday: <u>75</u> yrs. | | 10. IF UNDER 1 YEAR: Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>-</u> | | 10b. KIND OF BUSINESS OR INDUSTRY: <u>-</u> | |
| 11. BIRTHPLACE (State or foreign country): <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME: <u>James Wheatley</u> | | 14. MOTHER'S MAIDEN NAME: <u>Mary Ellen Schaeffer</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY No.: <u>9</u> | |
| 17. INFORMANT & ADDRESS: <u>Hospital records</u> | | | |
| 18. MEDICAL CERTIFICATION | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | INTERVAL BETWEEN ONSET AND DEATH |
| 903.7 Immediate cause (a) <u>Auto cardiac failure</u> DUE TO | | | |
| Antecedent cause(s) (b) <u>Pneumonia</u> DUE TO | | | |
| Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>fracture of hip</u> | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Accident</u> | | | |
| 19a. DATE OF OPERATION: <u>0</u> | | 19b. MAJOR FINDING OF OPERATION: | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Hospital</u>) | |
| 21c. (City or town) (County) (State) | | <u>Catonville Baltimore - Md.</u> | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>5</u> <u>21</u> <u>1955</u> <u>7a.m.</u> | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 21f. HOW DID INJURY OCCUR? <u>Fell on left side on floor</u> | | | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| SIGNATURE <u>Dr. McKie</u> | | 1010 reads on | |
| CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED <u>May 30 55</u> | |
| DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | |
| M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/> | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u> | | DATE THEREOF <u>JUNE 2, 1955</u> | |
| NAME OF CEMETERY OR CREMATORY <u>PARKWOOD</u> | | LOCATION (City, town, or county) (State) <u>BALTIMORE CO. Md.</u> | |
| DATE REC'D BY LOCAL REG. <u>6-1-55</u> | | REGISTERAR'S SIGNATURE <u>A. W. H. ...</u> | |
| 24. FUNERAL DIRECTOR <u>Wm. Cook-Blight, Inc.</u> | | ADDRESS <u>6009 HARFORD Rd.</u> | |



4482

CERTIFICATE OF DEATH

Reg. Dist. No. 04420

| | | | | | | | |
|--|----------------------------|--|----------------------------------|---|------------------------------------|--|-----------------------|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY BALTIMORE | | MARYLAND | | STATE MD. | | COUNTY BALTIMORE | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) 52 CATONSVILLE | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) OWINGS MILLS | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 14 SPRING GROVE | | | | STREET ADDRESS (If rural give location) PLEASANT HILLS | | | |
| 3. NAME OF DECEASED: (First) EDWIN (Middle) WARREN (Last) WHITE | | | | 4. DATE (Month) (Day) (Year) OF DEATH: MAY 7 1955 | | | |
| 5. SEX: M | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE | 8. DATE OF BIRTH: 1/11/07 | 9. AGE last birthday: 48 yrs | IF UNDER 1 YEAR: Months Days Hours | | IF UNDER 24 HRS: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired): CLERK | | 10B. KIND OF BUSINESS OR INDUSTRY: OFFICE | | 11. BIRTHPLACE (State or foreign country): MD. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME: EDWIN G. WHITE | | | | 14. MOTHER'S MAIDEN NAME: CHATTYE ROLLINS | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No. (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.: ? | | 17. INFORMANT & ADDRESS: HOSPITAL RECORDS | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE (A) 752x TERMINAL PNEUMONIA. | | | | | | 1 WK. | |
| ANTECEDENT CAUSE (S) DUE TO HYDROCEPHALUS EPILEPSY | | | | | | YEARS | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. DUE TO HYDROCEPHALUS | | | | | | SINCE BIRTH | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. SCHIZOPHRENIA - 20YRS. | | | | | | | |
| 19A. DATE OF OPERATION: 0 | | 19B. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) INJURY OCCUR? Spring Grove Imp. | | (County) (State) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from NOV. 30, 1937 , to MAY 7, 1955 , that I last saw the deceased alive on MAY 7, 1955 , and that death occurred at 7:45 P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE Charles Ward M.D. | | ADDRESS M.D. Spring Grove Imp. | | DATE SIGNED 5/7/55 | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | DATE THEREOF May 9/55 | | NAME OF CEMETERY OR CREMATORY Druid Ridge | | LOCATION City, town, or county (State) Pikeville | |
| DATE REC'D BY LOCAL REGISTRAR 5/8/55 | | REGISTRAR'S SIGNATURE T.E. Harre | | 24. FUNERAL DIRECTOR J.F. Elmer | | ADDRESS Smoo Rustin Street Md. | |

MARGIN RESERVED FOR BINDING

BUREAU V. S.

MAY 10 1955

RECEIVED

CERTIFICATE OF DEATH

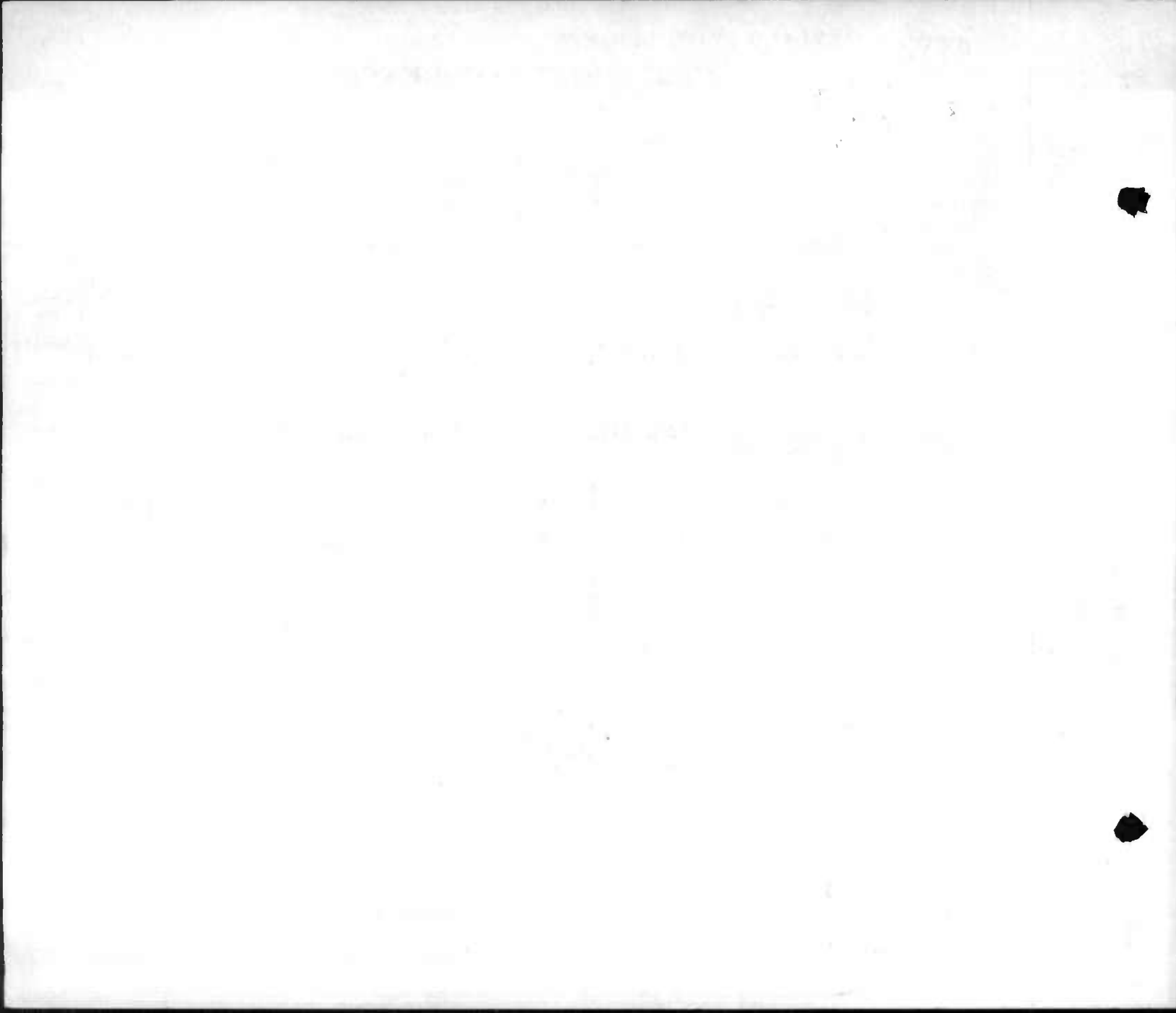
Reg. Dist. No.

| | | | | | |
|--|----------------------------------|---|---|--|---|
| 1. NAME OF DECEASED
(Type or Print) <i>Henry R. White</i> | | | 2. DATE OF DEATH
<i>5-1-55</i> | | |
| 3. PLACE OF DEATH:
A. <i>Baltimore City, Maryland</i>
B. FULL NAME OF HOSPITAL OR INSTITUTION
<i>Harlem Lane</i>
<i>52 Caton Ridge Nursing Home</i>
C. Length of stay in Baltimore
<i>90</i> Yrs. Mos. Days | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
<i>Md.</i>
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
<i>Baltimore</i>
D. STREET ADDRESS (If rural, give location)
<i>3841 Elmley Ave.</i> | | |
| 5. SEX
<i>male</i> | 6. COLOR OR RACE
<i>white</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
<i>Married</i> | 8. DATE OF BIRTH
<i>Nov. 6, 1881</i> | 9. AGE (In years last birthday)
<i>73</i> | 10. Under 1 Year Months: Days
11. Under 24 Hours Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Rtd - Self Employed</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Carpenter</i> | | |
| 13. FATHER'S NAME
<i>Henry E. White</i> | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
<i>no 3</i> | | | 16. SOCIAL SECURITY NO.
<i>214-03-3574</i> | | |
| 17. INFORMANT
<i>Mrs. E. W. Percy-3409 White Ave.</i> | | | ADDRESS | | |
| 18. <i>148X</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
<i>Carcinomatosis</i>
DUE TO
<i>Carcinoma of Throat</i>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
<i>Carcinoma of Throat</i>
DUE TO | | | INTERVAL BETWEEN ONSET AND DEATH
<i>?</i>
<i>?</i> | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| IF OPERATION WAS RELATED TO CAUSE OF DEATH. ENTER IN PART I OR PART II | | 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>April 28</i> 19 <i>55</i> to <i>May 1</i> 19 <i>55</i> , that (I) (we) last saw the deceased alive on <i>April 28</i> 19 <i>55</i> and that death occurred at <i>9:05 p.m.</i> from the causes and on the date stated above. | | | | | |
| 23A. SIGNATURE
<i>Paul Bleier</i>
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 23B. ADDRESS
<i>1801 W Baltimore St</i> | | 23C. DATE SIGNED
<i>5-1-55</i> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>5/4/55</i> | | 24C. NAME OF CEMETERY OR CREMATORY
<i>Moreland Mem. Pk.</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>Balto. Co. Md.</i> | | | | | |
| DATE RECEIVED BY LOCAL REGISTRAR
<i>5-2-55</i> | | REGISTRAR'S SIGNATURE
<i>A W Hedrick</i> | | 25. FUNERAL DIRECTOR
<i>Wm. J. Dickerson & Sons</i> | |

MIL CERTIFICATION

PLEASE TYPE, OR WITH PERMANENT RECORD, THIS A PERMANENT RECORD. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. HIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER THE DEATH.

The



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04472

4341

CERTIFICATE OF DEATH

Reg. Dist. No. 41

| | | | | | | | |
|---|--------------------------------|---|---------------------------------------|---|--|--|---|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>BALTIMORE</u> | | MARYLAND | | STATE <u>MARYLAND</u> | | COUNTY <u>BALTIMORE</u> | |
| CITY (If outside corporate limits, write OR and give nearest town) <u>DUNDALK</u> | | LENGTH OF STAY (if in this place) <u>1 year</u> | | CITY (If outside corporate limits, write OR and give nearest town) <u>DUNDALK</u> | | <u>53</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7267 HOLABIRD AVE</u> | | | | STREET ADDRESS (If rural give location) <u>7267 HOLABIRD AVE</u> | | | |
| 3. NAME OF DECEASED: (First) <u>LEWIS</u> (Middle) <u>EDWARD</u> (Last) <u>WHITE</u> | | | | 4. DATE OF DEATH: (Month) <u>MAY</u> (Day) <u>29</u> (Year) <u>1955</u> | | | |
| 5. SEX: <u>MALE</u> | 6. COLOR OR RACE: <u>WHITE</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u> | 8. DATE OF BIRTH: <u>AUG. 14 1870</u> | 9. AGE last birthday: <u>84</u> yrs. | | IF UNDER 1 YEAR: Months Days Hours Min. | |
| 10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>FARMER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY: <u>OWN FARM</u> | | 11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME: <u>HAGAR WHITE</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>LUCINDA HAILEIGH</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unk.) <u>4 No</u> | | 16. SOCIAL SECURITY No.: <u>—</u> | | 17. INFORMANT & ADDRESS: <u>MRS LILLIAN MULLINX DUNDALK MD.</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | | Interval Between Onset And Death |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| 420.1 Immediate cause (a) <u>Coronary Phrombosis</u> | | | | | | | |
| Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Arterio Sclerosis C.V. Disease</u> | | | | | | | |
| (c) <u>Generalized Arterio Sclerosis</u> | | | | | | | |
| 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | | | |
| 19a. DATE OF OPERATION: <u>0</u> | | | | 19b. MAJOR FINDINGS OF OPERATION | | | 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | | PLACE (Home, farm, factory, street, office bldg., etc.) | | (CITY OR TOWN) | | (COUNTY) (STATE) | |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Jan. 1955</u> , to <u>May 29, 1955</u> , that I last saw the deceased alive on <u>May 15, 1955</u> , and that death occurred at <u>8:45 P</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Joseph P. Mochanal</u> (Degree or title) | | | | ADDRESS <u>6714 Holabird Ave</u> DATE SIGNED <u>5/29/55</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | DATE THEREOF <u>JUNE 1 1955</u> | | NAME OF CEMETERY OR CREMATORY <u>HOWARD CHAPEL</u> | | LOCATION (City, town, or county) (State) <u>LONG CORNER, HOWARD Co MD.</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>JUNE 1-1955</u> | | REGISTRAR'S SIGNATURE <u>William M Kelly</u> | | 24. FUNERAL DIRECTOR <u>Olin L. Mochanal</u> | | ADDRESS <u>Damascus, Md.</u> | |

BUREAU V. S.

JUN 3 1955

RECEIVED

04473

MARYLAND

STATE DEPARTMENT OF HEALTH

4484

CERTIFICATE OF DEATH

Reg. Dist. No. 33

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED
STATE <u>Maryland</u> COUNTY <u>Baltimore</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN <u>Reisterstown</u> | | CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN <u>Reisterstown</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
<u>411 Main Street</u> | | STREET ADDRESS (If rural, give location)
<u>411 Main Street</u> | |
| 3. NAME OF DECEASED
(Type or Print) <u>GOLDIE</u> (First) <u>ETHEL</u> (Middle) <u>WINTERS</u> (Last) | | 4. DATE OF DEATH
(Month) <u>May</u> (Day) <u>18</u> (Year) <u>1955</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u> | 8. DATE OF BIRTH
<u>November 4, 1887</u> |
| 9. AGE last birthday
<u>67</u> yrs. | | 10. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>James Buckingham Cole</u> | | 14. MOTHER'S MAIDEN NAME
<u>Susan Rebecca Long</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO.
<u>216-28-7485</u> | |
| 17. INFORMANT AND ADDRESS
<u>Mrs. Clyde Worrall, Reisterstown, Md.</u> | | | |
| 18. MEDICAL CERTIFICATION | | | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | |
| 1534 Immediate cause (a) <u>Cardiac Failure</u> | | | <u>2 hours</u> |
| Antecedent cause(s) (b) <u>Carcinoma of Descending Colon</u> | | | <u>4 months</u> |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) | | | |
| II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY?
Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | | PLACE (Home, farm, factory, street, office bldg., etc.) | |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | |
| HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>54</u> , to <u>May 18</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 18</u> , 19 <u>55</u> , and that death occurred at <u>7:40 p.m.</u> , from the causes and on the date stated above. | | | |
| SIGNATURE <u>Charles E. McWilliams M.D.</u> | | ADDRESS <u>Reisterstown, Maryland</u> | |
| DATE SIGNED <u>May 18, 1955</u> | | | |
| 23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> | | DATE <u>May 21-1955</u> | |
| NAME OF CEMETERY OR CREMATORY <u>Winters Cemetery</u> | | LOCATION (City, town, or county) <u>New Windsor, Md.</u> | |
| DATE REC'D BY LOCAL REG. <u>5-20-55</u> | | REGISTRAR'S SIGNATURE <u>Mary B. Eline</u> | |
| 24. FUNERAL DIRECTOR | | ADDRESS <u>Wm. Berryman & Sons - Reisterstown, Md.</u> | |

MARGIN RESERVED FOR BINDING

M

I

BUREAU V. 3

MAY 25 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4485 CERTIFICATE OF DEATH

04474

Reg. Dist. No. 49

| | | | | | | | |
|--|-------------------|--|-------------------|--|-----------------|--|------------|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY BALTIMORE | | MARYLAND | | STATE MARYLAND | | COUNTY | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) OR | | | |
| X TOWN FORT HOWARD | | 12 DAYS | | TOWN BALTIMORE | | | |
| HOSPITAL OR INSTITUTE OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| 50 VETERANS ADMINISTRATION HOSPITAL | | | | 5 SOUTH DECKER AVENUE | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | | | 4. DATE (Month) (Day) (Year) | | | |
| DECEASED: (Type or Print) WALTER J. WOJTKOWSKI | | | | OF DEATH: MAY 16 1955 | | | |
| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH: | 9. AGE last birthday | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| MALE | WHITE | MARRIED | March 1, 1921 | 34 yrs. | Months | Days | Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): | | 10B. KIND OF BUSINESS OR INDUSTRY: | | 11. BIRTHPLACE (State or foreign country): | | 12. CITIZEN OF WHAT COUNTRY? | |
| Maintenance - Foreman | | Packing Company | | B ALTIMORE, MARYLAND | | U. S. A. | |
| 13. FATHER'S NAME: | | | | 14. MOTHER'S MAIDEN NAME: | | | |
| WALTER WOJTKOWSKI | | | | JOSEPHINE MN: UNKNOWN | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | | | 17. INFORMANT & ADDRESS: | | | |
| YES 2 WW II | | | | CLIN.REC.VET.ADM.HOSPITAL, FT. HOWARD, MD. | | | |
| 16. MEDICAL CERTIFICATION | | | | | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (A) CHRONIC GLOMERULONEPHRITIS | | | | | | UNKNOWN | |
| ANTECEDENT CAUSE (S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO | | | | | | | |
| (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: | | | | 19B. MAJOR FINDINGS OF OPERATION | | | |
| 0 | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc. | | 21C. WHERE DID (City or town) (County) (State) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from MAY 4, 1955, to MAY 16, 1955, and that death occurred at 12:15 M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE Francis G. Dickey, M.D., Chief, Medical Service, VAH, Fort Howard, Maryland | | | | DATE SIGNED 5-16-55 | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | NAME OF CEMETERY OR CREMATORY | | | |
| Burial | | | | Holy Rosary Cemetery | | | |
| DATE REC'D BY LOCAL REGISTRAR | | | | LOCATION (City, town, or county) (State) | | | |
| 5-17-55 | | | | Baltimore 22, Maryland | | | |
| REGISTRAR'S SIGNATURE | | | | 24. FUNERAL DIRECTOR | | | |
| A W Hedberg | | | | ADDRESS | | | |
| | | | | Wm. Cook-Blight, Inc. 6009 Harford Road | | | |
| | | | | Baltimore 14, Maryland | | | |

REPORT OF THE STATE HEALTH COMMISSIONER

FOR THE YEAR 1910

AND FOR THE YEAR 1911

AS REQUIRED BY CHAPTER 106A, § 1

OF THE ACT OF 1909

AND BY CHAPTER 106B, § 1

OF THE ACT OF 1910

AND BY CHAPTER 106C, § 1

OF THE ACT OF 1911

AND BY CHAPTER 106D, § 1

OF THE ACT OF 1912

AND BY CHAPTER 106E, § 1

OF THE ACT OF 1913

AND BY CHAPTER 106F, § 1

OF THE ACT OF 1914

AND BY CHAPTER 106G, § 1

OF THE ACT OF 1915

AND BY CHAPTER 106H, § 1

OF THE ACT OF 1916

AND BY CHAPTER 106I, § 1

OF THE ACT OF 1917

AND BY CHAPTER 106J, § 1

OF THE ACT OF 1918

AND BY CHAPTER 106K, § 1

OF THE ACT OF 1919

AND BY CHAPTER 106L, § 1

OF THE ACT OF 1920

AND BY CHAPTER 106M, § 1

OF THE ACT OF 1921

AND BY CHAPTER 106N, § 1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4486 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 3

04475
Reg. Dist.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Baltimore</u> | | MARYLAND | | STATE <u>Md.</u> | | COUNTY <u>Carroll</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits write RURAL and give nearest town) | | | |
| TOWN <u>Randallstown</u> | | <u>Passing through</u> | | TOWN <u>(Gist) Sykesville, Md.</u> <u>06X-2</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | Route 26
<u>North Branch</u> | | STREET ADDRESS (If rural, give location)
<u>Klee Mill Rd. - R.F.D. 2</u> ✓ | | | |
| 3. NAME OF DECEASED: | | | | 4. DATE OF DEATH | | | |
| (First) <u>Charles</u> | | (Middle) <u>Dorner</u> | | (Last) <u>Woodward</u> | | (Month) <u>May</u> (Day) <u>3</u> (Year) <u>19 55</u> | |
| 5. SEX: <u>M</u> | | 6. COLOR OR RACE: <u>W</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u> | | 8. DATE OF BIRTH: <u>3/13/05</u> | |
| 9. AGE last birthday: <u>50</u> yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Machanic</u> | | 10b. KIND OF BUSINESS OR INDUSTRY: <u>Automobile</u> | | 11. BIRTHPLACE (State or foreign country): <u>Baltimore, Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u> | | 13. FATHER'S NAME: <u>William D. Woodward</u> | | 14. MOTHER'S MAIDEN NAME: <u>Ella Crieese</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> | | (If Yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY No.: <u>216-03-8296</u> | | 17. INFORMANT & ADDRESS: <u>Route 2 - Sykesville, Md.</u>
<u>Mrs. Julia Ann Woodward</u> | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | | | | | |
| Immediate cause (a) <u>420.1</u> <u>Coronary Artery Disease</u> | | | | | | <u>30 min.</u> | |
| DUE TO | | | | | | | |
| Antecedent cause(s) (b) <u>Hypertensive C.V. Disease</u> | | | | | | <u>2 yrs.</u> | |
| Diseases or conditions, if any, giving rise to the above cause DUE TO | | | | | | | |
| stating underlying cause last (c) | | | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u> | | | | | | | |
| 19a. DATE OF OPERATION: <u>None</u> | | | | 19b. MAJOR FINDING OF OPERATION: <u>None</u> | | | |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>None</u> | | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) <u>None</u> | | 21c. (City or town) (County) (State) | | | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u> M. | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <u>None</u> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| SIGNATURE <u>D. D. Gables</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED <u>5/4/55</u> | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u> | | DATE THEREOF <u>5/6/55</u> | | NAME OF CEMETERY OR CREMATORY <u>Bethesda</u> | | LOCATION (City, town, or county) (State) <u>Gist, Md.</u> | |
| DATE RECD BY LOCAL REG. <u>5/6/55</u> | | REGISTRAR'S SIGNATURE <u>Don E. Martin</u> | | 24. FUNERAL DIRECTOR <u>Arthur H. Wright</u> | | ADDRESS <u>Sykesville, Md.</u> | |

BUREAU V. S.

MAY 9 1955

RECEIVED

4487

CERTIFICATE OF DEATH

Reg. Dist. No.

04476

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <i>Baltimore</i> | MARYLAND | STATE <i>Md</i> | COUNTY <i>Baltimore</i> |
| CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN <i>Granite</i> | LENGTH OF STAY (in this place)
<i>65 years</i> | CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN <i>Granite</i> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
<i>00</i> | | STREET ADDRESS (If rural give location) | |
| 3. NAME OF DECEASED: | | 4. DATE (Month) (Day) (Year) | |
| (First) (Middle) (Last)
<i>Philip Frederick Zepp, Sr.</i> | | OF DEATH: <i>May 8 1955</i> | |
| 5. SEX: <i>Male</i> | 6. COLOR OR RACE: <i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH: <i>married Sept 28, 1888</i> |
| 9. AGE last birthday: <i>66</i> yrs. | | 10. IF UNDER 1 YEAR: Months Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Shoemaker</i> | | 10B. KIND OF BUSINESS OR INDUSTRY: <i>Shoey Store</i> | |
| 11. BIRTHPLACE (State or foreign country): <i>Md.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME: <i>George R. Zepp</i> | | 14. MOTHER'S MAIDEN NAME: <i>Emma Albright</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>unk -</i> | |
| 17. INFORMANT & ADDRESS: <i>Mrs Mabel M. Zepp - Granite, Md.</i> | | | |
| 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | |
| 421.4 IMMEDIATE CAUSE | | | |
| ANTECEDENT CAUSE (S) | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. | | | |
| (A) <i>Chr. Valvular Heart Disease</i> | | | |
| (B) <i>Decompensation</i> | | | |
| (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19A. DATE OF OPERATION: <i>0</i> | | 19B. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) | |
| 21C. WHERE DID (City or town) (County) (State) | | 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | |
| 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <i>1951</i> , to <i>5/7/55</i> , that I last saw the deceased alive on <i>5/7/55</i> , and that death occurred at <i>9:00 A.M.</i> from the causes and on the date stated above. | | | |
| SIGNATURE <i>Wm. E. Martus</i> | | ADDRESS <i>M. D. Roudalltown</i> | |
| DATE SIGNED <i>5/9/55</i> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | DATE THEREOF <i>5-11-55</i> | |
| NAME OF CEMETERY OR CREMATORY <i>Lorraine Park</i> | | LOCATION (City, town, or county) (State) <i>Woodlawn, Balt. Md.</i> | |
| DATE REC'D BY LOCAL REGISTRAR <i>5/9/55 Wm. E. Martus</i> | | 24. FUNERAL DIRECTOR ADDRESS <i>Arthur A. Haight - Sykesville, Md.</i> | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 11 1955

RECEIVED

2-11-55

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04477

4348

CERTIFICATE OF DEATH

Reg. Dist. No.....

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN Baltimore Highlands
HOSPITAL OR INSTITUTION OR STREET ADDRESS 2909 Vermont Ave. | | 2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) 3701-4
TOWN
STREET ADDRESS (If rural give location) 1329 Glyndon Ave. Balto., Md | |
| 3. NAME OF DECEASED
(First) (Middle) (Last)
Frank C. Zydellis (Zidler--Zidelis) | | 4. DATE OF DEATH
(Month) (Day) (Year)
May 31, 1955 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widower | 8. DATE OF BIRTH
October 22, 1886-68 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Iron Worker | | 10b. KIND OF BUSINESS OR INDUSTRY
Beth. Steel | 11. BIRTHPLACE (State or foreign country)
Lithuania |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 13. FATHER'S NAME
Unknown | |
| 14. MOTHER'S MAIDEN NAME
Unknown | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) ***** | |
| 16. SOCIAL SECURITY No.
213-07-3939 | | 17. INFORMANT
Matilda Zydellis 2909 Vermont Ave. | |
| 18. MEDICAL CERTIFICATION | | | |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
163X Immediate cause (a) Pulmonary Hemorrhage
Antecedent cause(s) (b) Ca of lungs
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) | | | INTERVAL BETWEEN ONSET AND DEATH
1 da
6 wks |
| II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY?
Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | | PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE) | |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | |
| HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from 5/1/55 to 5/31/55 , that I last saw the deceased alive on 5/31/55 , and that death occurred at 8 a.m. , from the causes and on the date stated above.
SIGNATURE Joseph E. Calkins M.D. ADDRESS 679 W. Chelton Blvd - DATE SIGNED 6/3/55 | | | |
| 23. BURIAL, CREMATION REMOVAL (Specify)
Burial | | DATE THEREOF
June 4, 1955 | |
| NAME OF CEMETERY OR CREMATORY
Holy Redeemer | | LOCATION (City, town, or county) (State)
Belair Road Balto., Md. | |
| DATE REC'D BY LOCAL REG.
6-3-55 | | REGISTRAR'S SIGNATURE
Chas. W. Kachauskas | |
| 24. FUNERAL DIRECTOR
Chas. W. Kachauskas | | ADDRESS
703 McHenry St. Balto., 30 Md. | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

